Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2701
Local Reg. No. 156
Reg. Dist. No. 220

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce — JUL 12 1967 — 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston — Bureau of Vital Statistics — c. LENGTH OF STAY IN THIS PLACE 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1005 Airway Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NORA	BELLE	DIEMART	24 June 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	25 Sept 1896	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 71	Own Home	Modoc, Calif.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
PrestonnJewett	no record	Rose Bebee	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	571 36 2082T	Norris A. Diemart	Lewiston, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occ — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Hemorrhage — 4 days

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 196_, *to* June 24, 1967, *that I last saw the deceased alive on* June 24, 1967, *and that death occurred at* 2:50 AM., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
John E. Carrow MD (Degree or title)	Lewiston Idaho	6-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	28 June 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-30-67	Lynette Knoll	W E Black — Malcom's Brower-Wann Memorial Chapel	E426

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME:

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended August 9, 1967

Certificate of Death

STATE OF IDAHO

State File No. 2702
Local Reg. No. 155
Reg. Dist. No. 220

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 188 Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location) P. O. Box 243

3. NAME OF DECEASED (Type or Print) a. (First) Jack b. (Middle) c. (Last) Maynard

4. DATE OF DEATH (Month) June (Day) 25, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 26 Nov. 1907

9. AGE (In years last birthday) 59 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator 17

10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill

11. BIRTHPLACE (State or foreign country) Colton (Johnson), Washington

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thad Maynard
BIRTHPLACE Oregon

14. MOTHER'S MAIDEN NAME Maude Richardson
BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW 2

16. SOCIAL SECURITY NO. 159-03-6506

17. INFORMANT'S OWN SIGNATURE Mrs. Jack Maynard
ADDRESS Orofino, Ida.

18. CAUSE OF DEATH 5021
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Bronchitis — yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 16, 1967, *to* June 25, 1967, *that I last saw the deceased alive on* June 25, 1967, *and that death occurred at* 3:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 013 (Degree or title)
John W. Armstrong, M.D.

23b. ADDRESS 307 St. Johns Way, Lewiston

23c. DATE SIGNED 6-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 29 June 1967

24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 6-30-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER W. E. Black

LICENSE NO. E 426

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
AUG 7 - 1967
Bureau of Vital Statistics

State of IDAHO
County of Clearwater } ss.

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Jack Cecil Maynard (Name on Original Certificate) who died (Was Born or Died) on June 25, 1967 (Date of Event)
in Lewiston, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Certificate of Marriage (Bible Record, Insurance Policy, Etc.) prepared on September 25, 1961 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name of Deceased	Jack Cecil Maynard	Jack Maynard

Subscribed and sworn to before me this 3rd day of August 1967

Notary Public, residing at ORofino, Idaho

My commission expires .....

(Seal)

Signed Ralph A. Haley
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

.....
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of IDAHO
County of CLEARWATER } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 3rd day of August 1967

Notary Public, residing at Orofino, Idaho

My commission expires June 17, 1970

(Seal)

Signed Cecile Maynard
(Signature of Any Credible Person)

ORofino Idaho
(Street Address, City, State)

FORM DH 60-155

L. 7-31-67 H

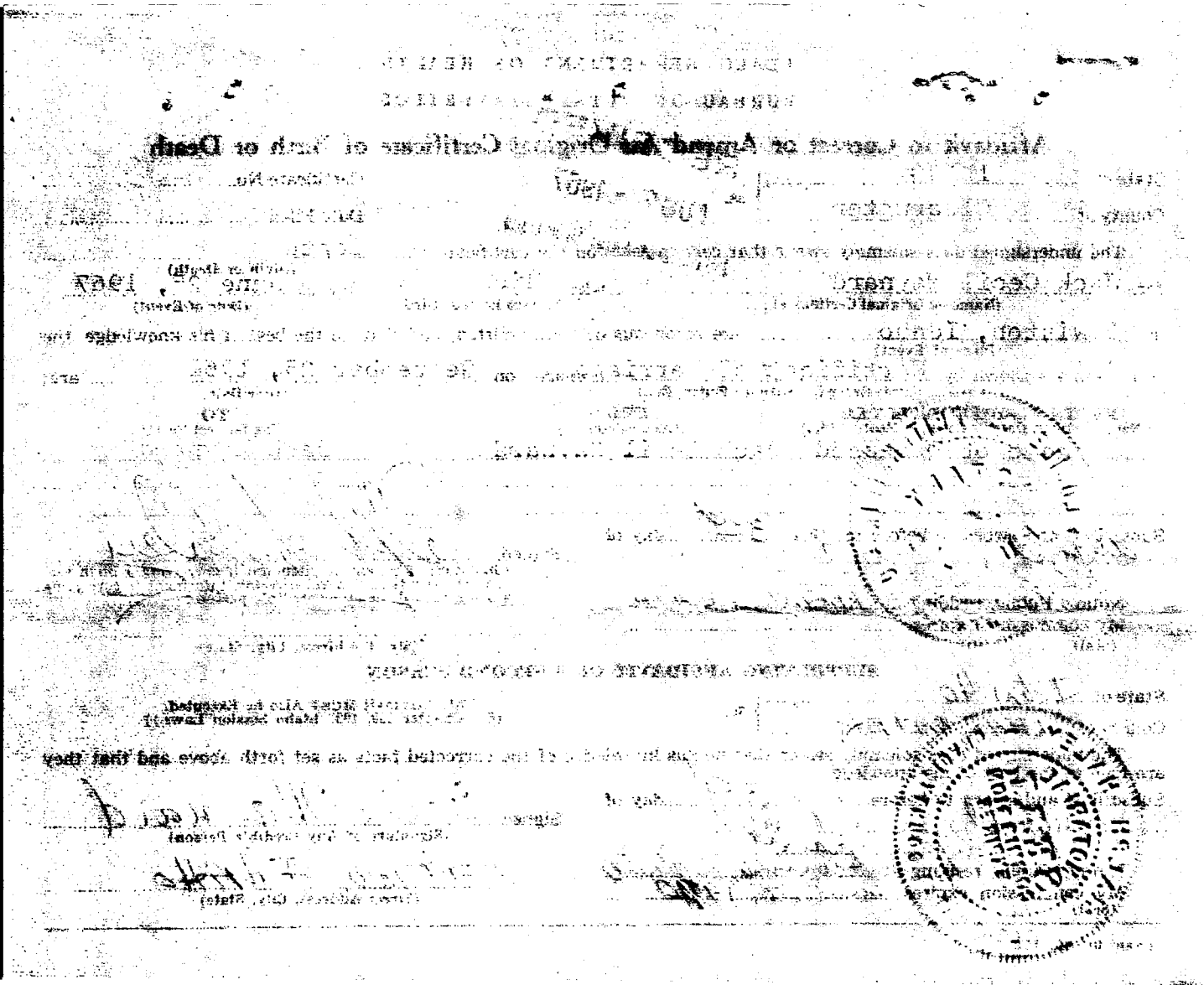

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REC

Certificate of Death

STATE OF IDAHO

State File No. 2702
Local Reg. No. 153
Reg. Dist. No. 220

BIRTH NO.

JUL 12 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): P O Box - 243

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JACK	CECIL	MAYNARD	25 June 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	26 Nov. 1907	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machine Operator	Lumber Mill	Colton (Johnson), Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thad Maynard	Oregon	Maude Richardson	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW-2	159 03 6506	Mrs Jack Maynard	Orofino, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5921

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) COR PULMONALE — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Bronchitis — yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* June 16, 1967, *to* June 25, 1967, *that I last saw the deceased alive on* June 25, 1967, *and that death occurred at* 3:25 PM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	307 ST LEWISTON Ida	6/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	29 June 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-30-67	Lynette Knott	W E Black Malcom's Brower-Wann Memorial Chapel	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

JUL 14 1967

DUTIES:

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(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
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ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2703
Local Reg. No. 157
Reg. Dist. No. 220

BIRTH NO.

RECEIVED
JUL 12 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 29
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Route

3. NAME OF DECEASED (Type or Print): a. (First) Randy; b. (Middle) Mike; c. (Last) Wolf

4. DATE OF DEATH: (Month) June (Day) 26, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: June 19, 1967

9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days: 7; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Moscow, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Larry A. Wolf
BIRTHPLACE: Unavailable

14. MOTHER'S MAIDEN NAME: Roberta Stoddard
BIRTHPLACE: Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Larry A. Wolf (Dad)
ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7730

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyaline Membrane Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 20, 1967, *to* June 26, 1967, *that I last saw the deceased alive on* June 26, 1967, *and that death occurred at* 1100 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert L Olson 397 (Degree or title): M.D.
23b. ADDRESS: 324 Fifth St. Lewiston Idaho
23c. DATE SIGNED: 7-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6-29-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: 6-30-67
REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: Bill Neff
LICENSE NO.: E-439

FIRM NAME: English Chapel, Coeur d'Alene,

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: 6-67-5831 JAN 6 1975

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2704
Local Reg. No. 163
Reg. Dist. No. 220

Certificate of Death

RECEIVED
JUL 19 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 336 - North Prospect

3. NAME OF DECEASED (Type or Print)
a. (First): ANN
b. (Middle): LOUISE
c. (Last): BACHARACH

4. DATE OF DEATH (Month) (Day) (Year): 27 June 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 7
8. DATE OF BIRTH: 18 Nov. 1948
9. AGE (In years last birthday): 18 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Sr. Hi. Sch.
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Billy Bacharach — BIRTHPLACE: Cheney, Wash.
14. MOTHER'S MAIDEN NAME: Priscilla Deavitt — BIRTHPLACE: Spokane, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: no record
17. INFORMANT'S OWN SIGNATURE: X [signature] — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): ventricular fibulation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): multiple head & body
DUE TO (c): injuries

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 6.27.67
19b. MAJOR FINDINGS OF OPERATION: avulsion muscles Rt Iliac crest, avulsion vessels Rt Colon
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Road 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Waha 13 Nezperce 350 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 6 26 67 8:15 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Auto accident

22. *I hereby certify that I attended the deceased from* 6.26, 1967, *to* 6.27, 1967, *that I last saw the deceased alive on* 6.27, 1967, *and that death occurred at* 3:25 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John F. Barnes, M.D. 028
23b. ADDRESS: 347 St Johns Way Lewiston Idaho
23c. DATE SIGNED: 6.28.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 29 June 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 7-7-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: W E Black — Malcom's Brower-WannMemorial Chapel
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2705
Local Reg. No. 158
Reg. Dist. No. 220

RECEIVED JUL 12 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 350 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston Manor 318

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY 555 Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clarkston
d. STREET ADDRESS (If rural, give location) 719 12th. Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ANNA	----------	GUSTAFSON	June	27	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	February 28, 1878	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homekeeper 01	Homekeeping	Vastergotland, Sweden	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		532-10-5090 D	Mrs. Robert C. Linthart	Clarkston, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Prostatic Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic H. Disease.
DUE TO (c) Arteriosclerosis.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Aseptic Necrosis R. H.p.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1967 *to* 6 23, 1967, *that I last saw the deceased alive on* 6 23, 1967, *and that death occurred at* 7:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thurman MD 114	1317 St. Chas Way Lewiston	7 3 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 30, 1967	Vineland Cemetery	Clarkston, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-5-67	Lynette Knott	Patrick Mahoney	E-492

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Merchant Funeral Home..Clarkston, Wn.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 12 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2706
Local Reg. No. 760
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 180 Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weippe
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JEWEL
b. (Middle) OWEN
c. (Last) BATTLES

4. DATE OF DEATH (Month) (Day) (Year) 27 June 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 20 Dec. 1887

9. AGE (In years last birthday) 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Owner/Operator 17

10b. KIND OF BUSINESS OR INDUSTRY Lumbering

11. BIRTHPLACE (State or foreign country) Humbolt County, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Battles
BIRTHPLACE Iowa

14. MOTHER'S MAIDEN NAME Achsah Kellum
BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 01 4844 A

17. INFORMANT'S OWN SIGNATURE + Charles H Battles
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis Rt Middle Cerebral Artery — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 28, 1967 *to* 6 30, 1967 *that I last saw the deceased alive on* 6 29, 1967, *and that death occurred at* 2:50 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS 347 St John Way

23c. DATE SIGNED 7 3 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 30 June 1967

24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 7-6-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER W E Black
Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-426

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME:

DUTIES:

JUL 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 6 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 11 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 23 2010

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2707
Local Reg. No. 154
Reg. Dist. No. 220

RECEIVED JUL 12 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 350 NezPerce 000
b. CITY OR TOWN Lewiston, (Rural)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Reeds, rest home 335

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 357 NezPerce
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) 121-15th Ave

3. NAME OF DECEASED (Type or Print): a. (First) Emma b. (Middle) L. c. (Last) Wicklund

4. DATE OF DEATH: (Month) June (Day) 29, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 19 1888

9. AGE (In years last birthday): 79 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Elgin, Ill.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Theodore Mutzfeldt — BIRTHPLACE: Homurg Germany

14. MOTHER'S MAIDEN NAME: Emma Kunke — BIRTHPLACE: Homurg Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 535-03-0447A

17. INFORMANT'S OWN SIGNATURE: Emma L. Wicklund — ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) Generalized Arteriosclerosis — 5 Years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Lewiston NezPerce Idah.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1 '66, *to* 6-29, 1967, *that I last saw the deceased alive on* 6-29, 1967, *and that death occurred at* 9:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 349 (Degree or title) MD

23b. ADDRESS: Lewiston Idaho

23c. DATE SIGNED: 6-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: June 30, 1967

24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

24d. LOCATION (City, town, or county) (State): Everett, Wash.

DATE REC'D BY LOCAL REG.: 6-29-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: Andrew H. Vassar — LICENSE NO.: E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2708
Local Reg. No. 13
Reg. Dist. No. 530

BIRTH NO.

RECEIVED JUN 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 360 Oneida
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad City
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home - 70 S 70 E 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 360 Oneida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad City
d. STREET ADDRESS (If rural, give location) 70 S 70 E SPOUSE: Loren L. Peck, Jr.

3. NAME OF DECEASED (Type or Print)
a. (First) OPAL CLEONE
b. (Middle) PETERSEN
c. (Last) PECK

4. DATE OF DEATH (Month) June (Day) 8 (Year) 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH Oct. 28, 1919

9. AGE (In years last birthday) 47
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY -

11. BIRTHPLACE (State or foreign country) Ridgedale, Oneida, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOSEPH FRANCIS PETERSEN
BIRTHPLACE HYRUM, UTAH

14. MOTHER'S MAIDEN NAME HANNAH SPENCE
BIRTHPLACE Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-30-2169

17. INFORMANT'S OWN SIGNATURE Loren L. Peck Jr
ADDRESS Malad, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 2nd adeno carcinoma ovary — 7 mo
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1966, *to* June 8, 1967, *that I last saw the deceased alive on* June 8, 1967, *and that death occurred at* 11:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS Malad City, Idaho

23c. DATE SIGNED June 10, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 12, 1967

24c. NAME OF CEMETERY OR CREMATORY Malad City Cemetery

24d. LOCATION (City, town, or county) (State) Malad, Oneida, Idaho

DATE REC'D BY LOCAL REG. June 10, 1967

REGISTRAR'S SIGNATURE

25. EMBALMER Raiford G. Benson

LICENSE NO. E-351

FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 23 1992

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2709
Local Reg. No. 14
Reg. Dist. No. 530

Certificate of Death

STATE OF IDAHO

RECEIVED JUN 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 360 Oneida
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Samaria
c. LENGTH OF STAY (in this place): -
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): - Home - 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 360
b. COUNTY: Oneida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Samaria
d. STREET ADDRESS (If rural, give location): - Rt 1 SPOUSE: William E. Morse

3. NAME OF DECEASED (Type or Print)
a. (First): SARA ANNIE
b. (Middle): EVANS
c. (Last): MORSE

4. DATE OF DEATH (Month) June (Day) 15 (Year) 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Sept. 29, 1883
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washakie, Box Elder, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: THOMAS EVANS — BIRTHPLACE: Wales
14. MOTHER'S MAIDEN NAME: ELIZABETH REESE — BIRTHPLACE: Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): - (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 518-46-9949
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Ogden, Utah

18. CAUSE OF DEATH 6000
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 9 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease
DUE TO (c): senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1966, *to* June, 1967, *that I last saw the deceased alive on* June 15, 1967, *and that death occurred at* 11:50a m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 3/5 (Degree or title): M.D.
23b. ADDRESS: Malad City, Idaho
23c. DATE SIGNED: June 16, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: June 19, 1967
24c. NAME OF CEMETERY OR CREMATORY: Samaria City Cemetery
24d. LOCATION (City, town, or county) (State): Samaria, Oneida, Idaho

DATE REC'D BY LOCAL REG.: June 16, 1967
REGISTRAR'S SIGNATURE: Ruth G. Sweeten
25. EMBALMER: Raiford G. Benson — LICENSE NO.: E-351

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

JUN 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 23 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2710
Local Reg. No. 35
Reg. Dist. No. 330

Certificate of Death

RECEIVED JUN 7 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF (in this place) 4 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 245 Payette Valley Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fruitland
d. STREET ADDRESS (If rural, give location) 715 1st St.

3. NAME OF DECEASED (Type or Print)
a. (First) Hollie
b. (Middle) Pearl
c. (Last) LaPorte

4. DATE OF DEATH (Month) June (Day) 1, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 21, 1890
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Siloam Springs, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Elms — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Jane Lawrence — BIRTHPLACE: Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. 519-22-7542A
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Payette, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Adenocarcinoma of colon with extensive metastases — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertensive cardiovascular disease — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1958, 19__, *to* 6-1-, 19 67, *that I last saw the deceased alive on* 5-30-67, 19__, *and that death occurred at* 9:45A. *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 574 (Degree or title) — 23b. ADDRESS: Payette, Idaho — 23c. DATE SIGNED: 6-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 3, 1967
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Payette, Idaho

DATE REC'D BY LOCAL REG.: June 3-1967
REGISTRAR'S SIGNATURE: Robert E. Shaffer
25. EMBALMER: Gifford R. Shaffer
LICENSE NO. E-344

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHAFFER MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 23 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2711
Local Reg. No. 36
Reg. Dist. No. 330

Certificate of Death

RECEIVED
JUN 7 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 315 No. 9th

3. NAME OF DECEASED (Type or Print)
a. (First) Margaret
b. (Middle) E.
c. (Last) Walton

4. DATE OF DEATH (Month) June (Day) 3, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: November 9, 1885
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Winona, Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: James McGill — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Mary Ann Hennessey — BIRTHPLACE: Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) - - -
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Marie L. Anderson — ADDRESS: Troy, Montana

18. CAUSE OF DEATH 260X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized atherosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes mellitus — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 19 54, *to* June 3, 1967, *that I last saw the deceased alive on* May 24, 19 67 *and that death occurred at* 3 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Thomas W. Watts Jr. M.D. 553 (Degree or title)
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 6/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: June 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Winona Cemetery
24d. LOCATION (City, town, or county) (State): Winona Minnesota

DATE REC'D BY LOCAL REG.: June 5-1967
REGISTRAR'S SIGNATURE: Robert E. Shaffer
25. EMBALMER: Gifford R. Shaffer
LICENSE NO.: E-344

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHAFFER MEMORY CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2712
Local Reg. No. 37
Reg. Dist. No. 330

RECEIVED
JUN 12 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley San. 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) ELVA
b. (Middle) ELIZABETH
c. (Last) HOPPER

4. DATE OF DEATH (Month) (Day) (Year) June 4, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Nov. 6, 1905
9. AGE (In years last birthday) 61 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Emmett, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Davison — BIRTHPLACE ----------
14. MOTHER'S MAIDEN NAME Eloise — BIRTHPLACE ----------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) ---------
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Phyllis R. Padgett — ADDRESS Boise, Idaho

18. CAUSE OF DEATH 2890
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Presenile Cortical Atrophy (Picks disease) — INTERVAL BETWEEN ONSET AND DEATH 8 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/12/66 *to* June 4, 1967, *that I last saw the deceased alive on* June 2, 1967, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Thomas W. Watts Jr. MD 523 (Degree or title)
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED 6/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE 6-4-67
24c. NAME OF CEMETERY OR CREMATORY Hillcrest
24d. LOCATION (City, town, or county) Weiser, Idaho (State)

DATE REC'D BY LOCAL REG. June 9-1967
REGISTRAR'S SIGNATURE Robert E. Schaffer
25. EMBALMER Marshall S. Dickerson
LICENSE NO. E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2713
Local Reg. No. 42
Reg. Dist. No. 330

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

JUL 13 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 380 Payette 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (In this place) 3mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Oregon 38
b. COUNTY 555 Malheur
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nyssa
d. STREET ADDRESS (If rural, give location) 614 N. 4th St

3. NAME OF DECEASED (Type or Print)
a. (First) Harry
b. (Middle) E
c. (Last) Collins

4. DATE OF DEATH (Month) (Day) (Year) 7-7-1967

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 12-15-1875
9. AGE (In years last birthday) 91 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY Builder
11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Collins — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Unk. — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 531-16-0568A
17. INFORMANT'S OWN SIGNATURE Alice Collins — ADDRESS 614 N. 4th St. Nyssa Oregon

18. CAUSE OF DEATH 4500
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized atherosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis obliterans legs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* July 7, 1967, *that I last saw the deceased alive on* July 1, 1967, *and that death occurred at* 6:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE Thomas W. Walk 553 (Degree or title) J.M.D.
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED 7/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-10-1967
24c. NAME OF CEMETERY OR CREMATORY Nyssa
24d. LOCATION (City, town, or county) Nyssa (State) Oregon

DATE REC'D BY LOCAL REG. July 10-67
REGISTRAR'S SIGNATURE Roberta E. Shaffer
25. FUNERAL DIRECTOR B.B. Lunkarmyer — ADDRESS Nyssa Oregon

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 3 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

State File No. 2714
Local Reg. No.
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

JUN 16 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 380 Payette 505

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette

c. LENGTH OF STAY (in this place) Few Min.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 3rd Ave. So. at Highway 52

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 380 b. COUNTY Payette

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Route (Star Route)

d. STREET ADDRESS (If rural, give location) Star Route

3. NAME OF DECEASED (Type or Print)

a. (First) Arnold b. (Middle) William c. (Last) Mordhorst

4. DATE OF DEATH (Month) June (Day) 10, (Year) 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH Dec. 12, 1901

9. AGE (In years last birthday) 65 yrs — IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer 04

10b. KIND OF BUSINESS OR INDUSTRY own farm

11. BIRTHPLACE (State or foreign country) Arcadia, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George H. Mordhorst BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Anna M. Seivers BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs. Grace Mordhorst ADDRESS Payette, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Occlusive Coronary — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — Years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I* ~~attended the deceased from~~ made ~~to~~ inquiry ~~to~~ ~~[illegible]~~ *on* June 10, 1967, *and that death occurred at* 11:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Hardy H Parkson 583 (Degree or title) Coroner 4

23b. ADDRESS Payette, Idaho

23c. DATE SIGNED 6-10-1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6-13-1967

24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery

24d. LOCATION (City, town, or county) (State) Payette, Idaho

DATE REC'D BY LOCAL REG. 6-13-1967

REGISTRAR'S SIGNATURE Roberta E. Shaffer

25. EMBALMER Gifford R. Shaffer LICENSE NO. E-344

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2715
Local Reg. No. 39
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED JUN 22 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 108
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 8 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 900 River St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 900 River St.

3. NAME OF DECEASED (Type or Print)
a. (First) Ray
b. (Middle) Andrew
c. (Last) Nelson

4. DATE OF DEATH (Month) June (Day) 15, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 8, 1892
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months -- Days -- IF UNDER 24 HRS. Hours -- Min. --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Pendelton, Oregon
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Andrew Nelson — BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME Adelaide (Unknown) — BIRTHPLACE (Unknown)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW I 3
16. SOCIAL SECURITY NO. 541-42-1320
17. INFORMANT'S OWN SIGNATURE Ruth M. Nelson — ADDRESS Payette Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) - - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 67, 19__, *to* 6-15-67, 19__, *that I last saw the deceased alive on* 6-15-67, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 574 (Degree or title) [signature]
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED 6-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 20, 1967
24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery
24d. LOCATION (City, town, or county) Payette, (State) Idaho

DATE REC'D BY LOCAL REG. 6-20-67
REGISTRAR'S SIGNATURE Roberta E. Shaffer
25. EMBALMER Gifford R. Shaffer
LICENSE NO. E-344

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shaffer Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 27 1967

JUN 29 1967

JUL 14 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2716
Local Reg. No. 40
Reg. Dist. No. 330

RECEIVED JUL 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN Payette
LENGTH OF STAY (in this place) 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitarium
d. STREET ADDRESS (If rural, give location) 634 3rd Ave. So.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Addie	Mae	Beeman	June 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	March 22, 1882	85	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Pueblo, Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank W. McCrumb	Illinois	Minnie Rathage	Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	— —	542-05-6529B	Leslie Freeman	Payette Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic heart disease & — years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) failure — 7 days
DUE TO (c) Senile dementia — 3 weeks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1961, 19____, *to* 6-22-67, 19____, *that I last saw the deceased alive on* 6-20-67 19____, *and that death occurred at* 12:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Payette, Idaho	6-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 26, 1967	Park View Cemetery	New Plymouth Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-26-67	Roberta Ed Koffer	Gifford L. Shaffer	E-344

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2717
Local Reg. No. 26
Reg. Dist. No. 500-602

RECEIVED
JUN 8 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power 390 315
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
LENGTH OF STAY (in this place) 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390 b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	EDWARD	WILLIAM	CRONKHITE	June 1, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 26, 1887	79	6	5		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Postmaster 08	U.S.P.O.	Allenville, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George P. Cronkhite	Wisconsin	Lettie Mitchell	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-46-7549A	Mrs. E. W. Cronkhite	Am. Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

33 IX

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive CVA — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Essential hypertension — 1 yr
DUE TO (c) Arteriolarsclerosis — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pain in lower back — 2 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 17, 1967, *to* May 31, 1967, *that I last saw the deceased alive on* May 31, 1967, *and that death occurred at* 2: A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. L. Harris	MD	American Falls, Idaho	June 5, '67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-3-67	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-6-67	Callene Hadfield	Bud Kelly	Bud Kelly E-467

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUN 13 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2718
Local Reg. No. 27
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 390 Power 315
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN American Falls
c. LENGTH OF STAY (in this place) 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ELVAN	ELLSWORTH	COX	June 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Feb. 26, 1892	75	3	9		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Odessa, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jesse P. Cox	Missouri	Sarah J. Beasley	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	519-40-4180	Vina M. Cox	Am. Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Pulmonary failure	1½ days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	emphysema	10 years
DUE TO (c)	Chronic asthma	15 years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Cardiac decompensation	10 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	None	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 15, 1956, *to* June 4, 1967, *that I last saw the deceased alive on* June 4, 1967, *and that death occurred at* 1:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. L. Harris 203	MD	American Falls, Idaho	6-7-'67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	6-8-67	Valley View Cemetery	Rockland, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-9-67	Colleen Hadfield	Bud Kelly Bud Kelly	E-467

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2719
Local Reg. No. 28
Reg. Dist. No. 500-602

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUN 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 390 Power 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 031
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 716 North Main Street

3. NAME OF DECEASED (Type or Print)
a. (First) HERSCHELL
b. (Middle) FRANCIS
c. (Last) STINGER

4. DATE OF DEATH (Month) (Day) (Year) June 9, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 1, 1925
9. AGE (In years last birthday) 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver--Poc. 27
10b. KIND OF BUSINESS OR INDUSTRY Construction Co
11. BIRTHPLACE (State or foreign country) Marsh Center, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Walter Stinger — BIRTHPLACE Ogden, Utah
14. MOTHER'S MAIDEN NAME Anna Elizabeth Gill — BIRTHPLACE Weston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War II 4
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs Betty La Vee Stinger — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8100

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Punctured rt. lung, punctured throat — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Train-truck accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 10 FMC Railroad crossing. 4 mi. 13 West Pocatello, 390 Power, Idaho
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 9, 1967 10:45 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Train-truck accident on railroad crossing

22. *I hereby certify that I ~~attended the deceased~~ I last saw the deceased dead~~ alive~~ on* June 9, 1967, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Bud Kelly 583 (Degree or title) Coroner 4
23b. ADDRESS American Falls, Idaho
23c. DATE SIGNED 6-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Jun. 12, 1967
24c. NAME OF CEMETERY OR CREMATORY Arimo Cemetery
24d. LOCATION (City, town, or county) (State) Arimo, Bannock, Idaho

DATE REC'D BY LOCAL REG. 6-16-67
REGISTRAR'S SIGNATURE Callum Hodfield
25. EMBALMER Conway Grant
LICENSE NO. E47

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 8 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 9 1967

MAR 10 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

JUN 27 1967

Bureau of Vital Statistics

State File No. 2720
Local Reg. No. 29
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 390 Power — 304
b. CITY OR TOWN (If outside corporate limits write RURAL and give township): American Falls
c. LENGTH OF STAY (In this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital — 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — 390
b. COUNTY: Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) LUCY — b. (Middle) MAE — c. (Last) ESTEP

4. DATE OF DEATH: (Month) June (Day) 16, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug. 8, 1896

9. AGE (In years last birthday): 70 — If under 1 year: Months 10, Days 8 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert M. Randall — BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Minerva McCarty — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-58-9179

17. INFORMANT'S OWN SIGNATURE: x Beulah D. Galloway — ADDRESS: Am. Falls Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sepsis from small bowel obstruction — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Obstruction & abscess following abdomino-perineal colectomy — 48 hours

DUE TO (c) Adenocarcinoma rectum Jan. 1966

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Essential hypertension — 10 years

1547

19a. DATE OF OPERATION: June 16, 1967

19b. MAJOR FINDINGS OF OPERATION: Pericolostomy abscessc peritonitis & small bowel obstruction

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 22, 1953 *to* June 16, 1967, *that I last saw the deceased alive on* June 16, 1967, *and that death occurred at* 4:25P m., *from the causes and on the date stated above.*

23a. SIGNATURE: 203 (Degree or Title) H. L. Harris M.D.

23b. ADDRESS: American Falls, Idaho

23c. DATE SIGNED: June 19, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6-20-67

24c. NAME OF CEMETERY OR CREMATORY: Fallsview Cemetery

24d. LOCATION (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: 6-22-67

REGISTRAR'S SIGNATURE: Colleen Hatfield

25. EMBALMER: Bud Kelly — Bud Kelly — LICENSE NO. E-467

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2721
Local Reg. No. 31
Reg. Dist. No. 501-602

BIRTH NO.

RECEIVED JUL 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 390 Power — 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls — LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 134

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — 390 — b. COUNTY: Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	IVA	ELIZABETH	GRANT		June	25,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Nov. 23, 1903	63	7	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Lewistown, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Steven George	England	Nancy D. Thomas	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-24-1074	Mrs Loyd Bates	Aberdeen, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

626X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Abscess — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-15- , 19 67, *to* 6-25- , 19 67 *that I last saw the deceased alive on* 6-25- , 1967, *and that death occurred at* 9:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. L. Davis	141	American Falls, Idaho	7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-28-67	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-8-67	Callum Hadfield	H. L. Davis	E-253

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 6 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2722
Local Reg. No. 40
Reg. Dist. No. 140

Certificate of Death

RECEIVED
JUN 27 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clarkia
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clarkia
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle)
c. (Last) Sodahl

4. DATE OF DEATH (Month) (Day) (Year) June 1, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 1
8. DATE OF BIRTH 6-11-1883
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Logger 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Personal Records — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-1-, 1967, *to* 6-1-, 1967, *that I last saw the deceased alive on* 6-1, 1967, *and that death occurred at* about 3:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE A. M. Peterson, M.D. 414 (Degree or title)
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 6-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-14-67
24c. NAME OF CEMETERY OR CREMATORY St Maries
24d. LOCATION (City, town, or county) St. Maries (State) Idaho

DATE REC'D BY LOCAL REG. 6-19-67
REGISTRAR'S SIGNATURE Dale L Cornell
25. EMBALMER Dale L. Cornell
LICENSE NO. E 406

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2723
Local Reg. No. 43
Reg. Dist. No. 140

RECEIVED JUN 27 1967 VITAL STATISTICS

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 402 Shoshone
b. CITY OR TOWN Wallace
Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 402 b. COUNTY Shoshone
c. CITY OR TOWN Wallace
d. STREET ADDRESS (If rural, give location) 211 Cedar Street

3. NAME OF DECEASED (Type or Print) a. (First) Edna b. (Middle) [illegible] c. (Last) Hanson

4. DATE OF DEATH (Month) June (Day) 10, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Dec. 17, 1898
9. AGE (In years last birthday) 68 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Driftwood, Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Hardison BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Martha Stafford BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-14-5684
17. INFORMANT'S OWN SIGNATURE Nancy Lee Hanson ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4207 Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Post radiation pleural effusion WHS

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1964, *to* June, 19 67, *that I last saw the deceased alive on* June 20, 19 67, *and that death occurred at* 7:50a m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 182 (Degree or title)
23b. ADDRESS Box 200 Wallace, Idaho
23c. DATE SIGNED 6-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Forest
24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. 6-19-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Dale L. Cornell
LICENSE NO. E 406

FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

66-11259

RECEIVED JUN 19 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2724
Local Reg. No. 38
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 402 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Providence 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 488 b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mullan
d. STREET ADDRESS (If rural, give location): Box 176

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Penny	Sue	Reed	June 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Never married	Oct. 25, 1966		7			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant 02		Wallace, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Louis Henry Reed	Idaho	Suzanne Fay Eby	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	x Louis H Reed	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CARDIAC FAILURE — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congenital Cardiac Defects (Multiple - major). — BIRTH
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pneumonitis — 2 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Birth, 19__, *to* 10 June, 1967, *that I last saw the deceased alive on* 10 June, 1967, *and that death occurred at* 4:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert J Terelli 435	MD	Wallace, Idaho	6/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 14, 1967	Mullan	Mullan, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-14-67	Dale Cornell	Dale L. Cornell	

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 2 7 2007

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2725
Local Reg. No. 39
Reg. Dist. No. 140

BIRTH NO.

RECEIVED JUN 19 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 401 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 403 b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location) Box 965

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) c. (Last) Capparelli Sr.

4. DATE OF DEATH (Month) (Day) (Year) June 11, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH June 6, 1896
9. AGE (In years last birthday) 71 If UNDER 1 YEAR Months Days If UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gunsmith
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Luiggi Capparelli BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-38-8722
17. INFORMANT'S OWN SIGNATURE X Mrs June C. Kroupa ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebrovascular Hemorrhage — 4 Mos
DUE TO (c) Cerebral arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 28, 1967 *to* June 11, 1967, *that I last saw the deceased alive on* June 11, 1967 *and that death occurred at* 10:40A *m., from the causes and on the date stated above.*

23a. SIGNATURE Orland B Scott M.D. (Degree or title)
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED June 14 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Missoula City
24d. LOCATION (City, town, or county) (State) Missoula Montana

DATE REC'D BY LOCAL REG. 6-16-67
REGISTRAR'S SIGNATURE Dale Cornell
25. EMBALMER Dale L. Cornell
LICENSE NO. E 406

FIRM NAME: Cornell's Ward Funeral

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2726
Local Reg. No. 46
Reg. Dist. No. 142

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
JUN 27 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone County Nursing Home 523

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 1724 West 4th Ave

3. NAME OF DECEASED (Type or Print)
a. (First) Iva
b. (Middle) M.
c. (Last) Petersen

4. DATE OF DEATH (Month) (Day) (Year) June 13, 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH Dec. 27, 1885
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife OX
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Cadott, Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles J. Smith — BIRTHPLACE Vermont
14. MOTHER'S MAIDEN NAME Lona Mae Johnson — BIRTHPLACE New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Darrell J. Petersen — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Gall Bladder — INTERVAL BETWEEN ONSET AND DEATH 18 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Jan 25 1967
19b. MAJOR FINDINGS OF OPERATION Common duct obstruction due carcinoma
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 22, 1967, *to* June 13, 1967, *that I last saw the deceased alive on* June 12, 1967, *and that death occurred at* 4:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Orland B. Scott 461 (Degree or title) M.D.
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED 6/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 17, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg (State) Idaho

DATE REC'D BY LOCAL REG. 6/22/67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Donald Maisel
LICENSE NO. 452

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUN 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2727
Local Reg. No. 41
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 402 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Street & River 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 402 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location) 408 River Street

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) Dale c. (Last) Huitt

4. DATE OF DEATH (Month) (Day) (Year) June 13, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married

8. DATE OF BIRTH Sept. 15, 1961

9. AGE (In years last birthday) 5
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Youngster 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Tucson, Arizona

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Donald Huitt
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Joy Coggins
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Donald C. Huitt
ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drown — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT (Specify) ~~SUICIDE~~ ~~HOMICIDE~~ accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street & River 18

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Wallace 13, Shoshone 402, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) JUNE 13 67 3 P m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Fell in river

22. *I hereby certify that I attended the deceased from* 6-13, 1967, *to* 6-13, 1967, *that I last saw the deceased alive on* 6-13, 1967, *and that death occurred at* about 3:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE C. M. Peterson, 414 (Degree or title) M.D.

23b. ADDRESS Wallace, Idaho

23c. DATE SIGNED 6-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6-16-67

24c. NAME OF CEMETERY OR CREMATORY Shoshone Memorial

24d. LOCATION (City, town, or county) (State) Pinehurst, Idaho

DATE REC'D BY LOCAL REG. 6-19-67

REGISTRAR'S SIGNATURE Dale Cornell

25. EMBALMER Dale L. Cornell

LICENSE NO. E 406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form PH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED — STATE OF IDAHO

JUN 27 1967 — Bureau of Statistics

State File No. 2728
Local Reg. No. 47
Reg. Dist. No. 142

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 701 SHOSHONE 204
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KELLOGG
c. LENGTH OF STAY IN THIS PLACE: 4 MONTHS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): WEST SHOSHONE GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 407 SHOSHONE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KELLOGG
d. STREET ADDRESS (If rural, give location): 205 W. MISSION

3. NAME OF DECEASED (Type or Print): a. (First) MERLE b. (Middle) S. c. (Last) McKAY

4. DATE OF DEATH: (Month) JUNE (Day) 14, (Year) 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): NEVER MARRIED

8. DATE OF BIRTH: SEPT. 7, 1906

9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHIFT BOSS

10b. KIND OF BUSINESS OR INDUSTRY: MINING

11. BIRTHPLACE (State or foreign country): MICHIGAN

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN McKAY — BIRTHPLACE: MICHIGAN

14. MOTHER'S MAIDEN NAME: ELLEN KERR — BIRTHPLACE: MICHIGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service): NONE

16. SOCIAL SECURITY NO.: 518-03-4458

17. INFORMANT'S OWN SIGNATURE: Lenore McKay — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia, Terminal — INTERVAL BETWEEN ONSET AND DEATH: 5-7 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Cecum — 1 Year

19a. DATE OF OPERATION: 12/2/66

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Cecum

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 21, 1966, *to* June 14, 1967, *that I last saw the deceased alive on* June 14, 1967, *and that death occurred at* 4:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Orland Brown MD 461 (Degree or title) 1

23b. ADDRESS: Kellogg Idaho

23c. DATE SIGNED: 6/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: JUNE 16, 1967

24c. NAME OF CEMETERY OR CREMATORY: GREENWOOD

24d. LOCATION (City, town, or county) (State): KELLOGG, IDAHO

DATE REC'D BY LOCAL REG.: 6/22/67

REGISTRAR'S SIGNATURE:

25. EMBALMER: Donald Maisel — LICENSE NO.: E452

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

JUN 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2729
Local Reg. No.
Reg. Dist. No.

RECEIVED JUL 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION West Shoshone Gen Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 487
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 302 West Mullan

3. NAME OF DECEASED (Type or Print) a. (First) Ray b. (Middle) L. c. (Last) McWOLF

4. DATE OF DEATH (Month) (Day) (Year) June 15, 1967

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec 30, 1887

9. AGE (In years last birthday) 79 IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Man

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Moca, Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Kennie McWOLF BIRTHPLACE Minnesota

14. MOTHER'S MAIDEN NAME Lillian Usher BIRTHPLACE Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-01-9488

17. INFORMANT'S OWN SIGNATURE Emma McWolf ADDRESS Kellogg, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prostatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 8-10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bronchopneumonia, Terminal 2 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 10, 1955, to June 16, 1967, that I last saw the deceased alive on June 16, 1967, and that death occurred at 11:05A m., from the causes and on the date stated above.

23a. SIGNATURE Orland B. Scott 461 (Degree or title) MD

23b. ADDRESS Kellogg Idaho

23c. DATE SIGNED 7/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 17, 1967

24c. NAME OF CEMETERY OR CREMATORY Greenwood

24d. LOCATION (City, town, or county) (State) Kellogg, Idaho

DATE REC'D BY LOCAL REG. 7/14/67

REGISTRAR'S SIGNATURE Joe Devine

25. EMBALMER Ronald Maisel

LICENSE NO. E452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 27 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2730
Local Reg. No. 58
Reg. Dist. No. 142

BIRTH NO.

RECEIVED JUL 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
c. LENGTH OF STAY IN (this place) Few Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Enroute To Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 481 b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 216 West Cameron

3. NAME OF DECEASED (Type or Print) a. (First) Wesley b. (Middle) H. c. (Last) Walden

4. DATE OF DEATH (Month) (Day) (Year) June 16, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH May 30, 1903

9. AGE (In years last birthday) 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocer 22

10b. KIND OF BUSINESS OR INDUSTRY Grocery

11. BIRTHPLACE (State or foreign country) Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 519-18-2944

17. INFORMANT'S OWN SIGNATURE Ronald V Walden — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Fractured Skull — INTERVAL BETWEEN ONSET AND DEATH: One hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fractured Neck
DUE TO (c) Multiple fractures of facial bones

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Severe lacerations of face, upper lip & left forehead
Multiple Contusions & abrasions of chest & both arms

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 10

21c. (CITY, TOWN, OR TOWNSHIP) near Cataldo 13 (COUNTY) Kootenai 280 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 6-16-67 8:15 a.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Tire blew out & ran off road

22. *I hereby certify that I attended the deceased from* 6-16, 1967, to 6-16, 1967, *that I last saw the deceased alive on* 6-16, 1967, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) G. M. Peterson, M.D. — **23b. ADDRESS** Wallace, Idaho — **23c. DATE SIGNED** 6-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** June 20, 1967 — **24c. NAME OF CEMETERY OR CREMATORY** Forest — **24d. LOCATION** (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. 6-30-67 — **REGISTRAR'S SIGNATURE** Joe Shine

25. EMBALMER Ronald Maisel — **LICENSE NO.** E452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 11 1967

JUL 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2731
Local Reg. No. 48
Reg. Dist. No. 142

BIRTH NO.

RECEIVED JUN 27 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Kellogg
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home at Big Creek 000

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Idaho 488
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Kellogg
d. STREET ADDRESS (If rural, give location) Sunshine Star Route

3. NAME OF DECEASED (Type or Print) a. (First) Laurene b. (Middle) E. c. (Last) Smith

4. DATE OF DEATH (Month) June (Day) 16 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Feb. 22, 1947

9. AGE (In years last birthday) 20 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Wallace, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Norman Smith BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Grace E. Waud BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None 3333

17. INFORMANT'S OWN SIGNATURE Norman M. Smith ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Drowning — INTERVAL BETWEEN ONSET AND DEATH 10 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Epileptic Seizure in
DUE TO (c) bath tub.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☒

21a. ~~ACCIDENT~~ ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 400 **(STATE)** Shoshon Idaho

21d. TIME OF INJURY (Month) June (Day) 16 (Year) 67 (Hour) 5:15 pm

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Drowned in Bath tub

22. *I hereby certify that I attended the deceased from* 1947, 19__, to 6-16-, 1967, *that I last saw the deceased alive on* 6-4-, 1967, *and that death occurred at* 5:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 052 (Degree or title) M D

23b. ADDRESS Kellogg Idaho

23c. DATE SIGNED 6.22.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE June 19, 1967

24c. NAME OF ~~CEMETERY~~ OR CREMATORY Hazen & Jaeger

24d. LOCATION (City, town, or county) (State) Spokane, Wash.

DATE REC'D BY LOCAL REG. 6/22/67

REGISTRAR'S SIGNATURE [signature]

25. EMBALMER Donald Maisel LICENSE NO. 452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2732
Local Reg. No. 42
Reg. Dist. No. 140

RECEIVED JUN 27 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 402 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
c. LENGTH OF STAY IN this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 402 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): Residence Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Dorothy	Molly	Murray	June 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	Feb. 3, 1920	47		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Spokane, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ivan R. Kirkpatrick	Unknown	Molly Reinhart	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			X Clifford J Murray	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1992 Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) primary site - pelvic (?). — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Not Attended, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 1:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert J Rennell	435 M.D. 1	Wallace, Idaho	6/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-21-67	Restlawn Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-19-67	Dale Cornell	Dale L. Cornell	E 406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under MAR 29 1968 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2733
Local Reg. No. 44
Reg. Dist. No. 140

BIRTH NO.

RECEIVED JUL 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Rural, Avery
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joe River 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 17 Kentucky
b. COUNTY 555 Fleming
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Flemingsburg
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Clayton b. (Middle) c. (Last) Beckett

4. DATE OF DEATH (Month) (Day) (Year) June 24, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH May 9, 1923

9. AGE (In years last birthday) 44 | If UNDER 1 YEAR: Months, Days | If UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Fleming County, Ky.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Otha Beckett, BIRTHPLACE Fleming Co., Ky.

14. MOTHER'S MAIDEN NAME Myrtle Smalley, BIRTHPLACE Fleming Co., Ky.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II 4

16. SOCIAL SECURITY NO. 400-36-1099

17. INFORMANT'S OWN SIGNATURE Douglas Beckett ADDRESS 502 Central Ave. Maysville, Ky.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drown — INTERVAL BETWEEN ONSET AND DEATH Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) S. Fork St. Joe River

21c. (CITY, TOWN, OR TOWNSHIP) Avery Rural (COUNTY) Shoshone (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 6-24-67 about 3 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Backed car into river

22. I hereby certify that I attended the deceased from 6-24-1967 to 6-24-1967, that I last saw the deceased alive on 6-24-1967, and that death occurred at about 3:00 A. m., from the causes and on the date stated above.

23a. SIGNATURE G. M. Peterson, M.D. (Degree or title) 414

23b. ADDRESS Wallace, Idaho

23c. DATE SIGNED 6-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6-28-67

24c. NAME OF CEMETERY OR CREMATORY Muses Mills Cemetery

24d. LOCATION (City, town, or county) (State) Fleming County, Kentucky

DATE REC'D BY LOCAL REG. 7-3-67

REGISTRAR'S SIGNATURE Dale Cornell

25. EMBALMER Dale L. Cornell LICENSE NO. E 406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Nos. 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 5 1967

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2734
Local Reg. No. 99
Reg. Dist. No. 142

BIRTH NO.

RECEIVED JUL 3 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 40 SHOSHONE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) KELLOGG
c. LENGTH OF STAY (In this place) 404 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) WEST SHOSHONE GEN. HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 40
b. COUNTY SHOSHONE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) KELLOGG
d. STREET ADDRESS (If rural, give location) 38 DEADWOOD GULCH

3. NAME OF DECEASED (Type or Print)
a. (First) HERSCHEL
b. (Middle)
c. (Last) PERKINS

4. DATE OF DEATH (Month) (Day) (Year) JUNE 26, 1967

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED

8. DATE OF BIRTH APRIL 23, 1921

9. AGE (In years last birthday) 46
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MINER 07

10b. KIND OF BUSINESS OR INDUSTRY MINING

11. BIRTHPLACE (State or foreign country) ARKANSAS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME UNKNOWN — BIRTHPLACE UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN — BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES
(If yes, give war or dates of service) W.W. II

16. SOCIAL SECURITY NO. 490-20-0870

17. INFORMANT'S OWN SIGNATURE Lynol E. Whitten — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of Larynx — INTERVAL BETWEEN ONSET AND DEATH 2-3 yrs ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 6/22/67

19b. MAJOR FINDINGS OF OPERATION None - Tracheotomy only

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 26, 1967, *to* June 26, 1967, *that I last saw the deceased alive on* June 26, 1967, *and that death occurred at* 4A m., *from the causes and on the date stated above.*

23a. SIGNATURE Orland B. Scott 461 (Degree or title) MD

23b. ADDRESS Kellogg Idaho

23c. DATE SIGNED 6/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE JUNE 29, 1967

24c. NAME OF CEMETERY OR CREMATORY OSBURN

24d. LOCATION (City, town, or county) OSBURN, (State) IDAHO

DATE REC'D BY LOCAL REG. 6-30-67

REGISTRAR'S SIGNATURE

25. EMBALMER Robert H. Ross — LICENSE NO. E-497

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2735
Local Reg. No. 45
Reg. Dist. No. 140

RECEIVED JUL 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 402 Shoshone
b. CITY OR TOWN Wallace
d. FULL NAME OF HOSPITAL OR INSTITUTION Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 403 b. COUNTY Shoshone
c. CITY OR TOWN Wallace
d. STREET ADDRESS 525 Cedar Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Hans		Monk	June	29	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Divorced 4	Nov. 10, 1895	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	Down, Ireland	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. I	518-03-3215	Hospital Records	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 24 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — unknown
DUE TO (c) Hypertensive cardiovascular disease — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 28 June, 1967, *to* 29 June, 1967, *that I last saw the deceased alive on* 29 June, 1967, *and that death occurred at* 2:45P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William W Dire 672 M.D.	Wallace	30 June 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 1, 1967	Nine Mile Cemetery	Wallace, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-3-67	Dale Cornell	Dale L. Cornell	E-406

FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2736
Local Reg. No. 5
Reg. Dist. No. 620

BIRTH NO.

RECEIVED JUN 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Teton 410 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 410
b. COUNTY: Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tetonia
d. STREET ADDRESS (If rural, give location): R. F. D.

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): JOHN
c. (Last): SENSENBACH

4. DATE OF DEATH (Month) (Day) (Year): June 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: 13 April 1888
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: 06 Laborer
11. BIRTHPLACE (State or foreign country): So. Heberton, Penn.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harry Frank Sensenbach — BIRTHPLACE: Rock Port, Penn.
14. MOTHER'S MAIDEN NAME: Marie Elizabeth Fuchs — BIRTHPLACE: Jeddo, Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: 520-12-4036
17. INFORMANT'S OWN SIGNATURE: Wm. C. Sensenbach — ADDRESS: Tetonia, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): ASHD — 6-8 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Pulmonary Emphysema — 5 years

4201

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-17, 1967, *to* 6-10, 1967, *that I last saw the deceased alive on* 6-10, 1967, *and that death occurred at* 9:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: K. Head M.D. 219 (Degree or title)
23b. ADDRESS: Driggs, Idaho
23c. DATE SIGNED: 6-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 14 June 1967
24c. NAME OF CEMETERY OR CREMATORY: Cache-Clawson Cemetery
24d. LOCATION (City, town, or county) (State): Tetonia, Teton Co., Idaho

DATE REC'D BY LOCAL REG.: 6-26-67
REGISTRAR'S SIGNATURE: Ella Griggs
25. EMBALMER: Robert Q. Bean
LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bean Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2737
Local Reg. No. 6
Reg. Dist. No. 620

BIRTH NO.

RECEIVED JUN 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Teton 410 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 410 b. COUNTY: Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Victor
d. STREET ADDRESS (If rural, give location): None Given

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	BENJAMIN	JONES	June 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	4 March 1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04	Farming	Morgan, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Benjamin Jones Sr.	Missouri	Louisa Tonks	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		529-18-4172	Wm E Jones	Portland, Oregon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Infarct — 3 days
DUE TO (c) ASHD

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July, 1961, *to* 6-11, 1967, *that I last saw the deceased alive on* 6-11, 1967, *and that death occurred at* 3:00A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
K Head 219	MD	Driggs, Idaho	6-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	14 June 67	Victor Cemetery	Victor, Teton Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-26-67	Edna Griggs	Robert A Bean	E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

MAR 10 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2738
Local Reg. No. 0-206
Reg. Dist. No. 460

Certificate of Death

RECEIVED JUN 12 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 427 3rd Avenue North

3. NAME OF DECEASED (Type or Print)
a. (First) ANNA
b. (Middle) C.
c. (Last) BRANSON

4. DATE OF DEATH (Month) (Day) (Year) June 6, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH October 1, 1893
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Wilbur, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME unknown — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-26-4001 A
17. INFORMANT'S OWN SIGNATURE Twin Falls, ADDRESS Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 7 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-31, 1967, *to* 6/7/, 1967, *that I last saw the deceased alive on* 6-7, 1967, *and that death occurred at* 1:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE Dean H. Affleck (Degree or title) 002
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 8 June 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 6/8/67
24c. NAME OF CEMETERY OR CREMATORY Wilbur Cemetery
24d. LOCATION (City, town, or county) (State) Wilbur, Nebraska

DATE REC'D BY LOCAL REG. 6-8-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Paul D. Reynolds
LICENSE NO. E-495

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 24 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 05 2000

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUN 12 1967 Bureau of Vital Statistics

State File No. 2739
Local Reg. No. 12-207
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 231 Twin Falls 000
b. CITY OR TOWN Twin Falls (If outside corporate limits, write RURAL and give township) DURATION OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Hospital 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240 b. COUNTY Gooding
c. CITY OR TOWN Hagerman
d. STREET ADDRESS (If rural, give location) Rural - 121 BlueSkies Village-CathedralCity, Also- Cali

3. NAME OF DECEASED (Type or Print) a. (First) SARA b. (Middle) B. c. (Last) ANDERSON

4. DATE OF DEATH (Month) (Day) (Year) June 7th, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 14, 1899
9. AGE (In years last birthday) 68 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Douglas, Kansas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME James H. Bissell BIRTHPLACE Valparaiso, Ind
14. MOTHER'S MAIDEN NAME Lizzie Cissne BIRTHPLACE Fremont, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 565-68-8262
17. INFORMANT'S OWN SIGNATURE A.U. Anderson ADDRESS Hagerman, Ida CathedralCity, Calif

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1250

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Left Ovary & Metastasis — INTERVAL BETWEEN ONSET AND DEATH 3 mon

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/29 1967, to 6/7, 1967, that I last saw the deceased alive on 6/7, 1967, and that death occurred at 7:30P m., from the causes and on the date stated above.

23a. SIGNATURE Roy D. Shamb M.D. 466 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 6.8.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6.12.67
24c. NAME OF CEMETERY OR CREMATORY Sunset MemorialParkCem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 6-9-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER
LICENSE NO. 343

FIRM NAME: White Mortuary-TwinFalls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2740
Local Reg. No. D-208
Reg. Dist. No. 460

Certificate of Death

RECEIVED JUN 16 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley Nursing Home 250

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 431 b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 480 Blue Lakes Blvd.

3. NAME OF DECEASED (Type or Print)
a. (First) CLARA b. (Middle) c. (Last) KOEHLER

4. DATE OF DEATH (Month) (Day) (Year) June 7, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH January 5, 1884
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Tekamah, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Coleman — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Lavina Slaughter — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-38-0043A
17. INFORMANT'S OWN SIGNATURE Louise K Lloyd — ADDRESS Bountiful, Utah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

170X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Left Breast — INTERVAL BETWEEN ONSET AND DEATH: 12-14 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastasis to Skull & Brain — 8-10 months
DUE TO (c) Metastasis to Ribs & Rt-Lung. — 8-10 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1948, *to* 6/71, 1967, *that I last saw the deceased alive on* 6-7, 1967, *and that death occurred at* 11:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Da. M. Crosby 338 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 6/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/12/67
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 6-13-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER James C. Reynolds — LICENSE NO. E-279
James C. Reynolds
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

490

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 16 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2741
Local Reg. No. D-213
Reg. Dist. No. 460

67-6005

BIRTH NO.

RECEIVED

JUN 16 1967

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH

a. COUNTY 421 Twin Falls

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

c. LENGTH OF STAY (in this place) 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 443

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY 421 Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

d. STREET ADDRESS (If rural, give location) 576 Harrison St. (Parents)

3. NAME OF DECEASED (Type or Print)

a. (First) Kathie

b. (Middle) Marie

c. (Last) Norton

4. DATE OF DEATH (Month) (Day) (Year) June 8, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NeverMarried 1

8. DATE OF BIRTH June 7, 1967

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 1 IF UNDER 24 HRS. Hours 9 Min. 08

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Claude L. Norton Jr. BIRTHPLACE Twin Falls, Ida.

14. MOTHER'S MAIDEN NAME Carol Blair BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE x Claude L. Norton Jr. ADDRESS Twin Falls,

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7735

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory arrest

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Prematurity - weight 1 #8 3/4 g 8 hours

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 8, 1967, *to* June 8, 1967, *that I last saw the deceased alive on* June 8, 1967, *and that death occurred at* 10:48a *m., from the causes and on the date stated above.*

23a. SIGNATURE Charles W. Schabach 456 (Degree or title) MD

23b. ADDRESS 111 6th Ave E. Twin Falls

23c. DATE SIGNED 6-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 10, 1967

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 6-14-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER [signature]

LICENSE NO. E-343

Federal Security Agency
United States Public Health Service

Form DH-65021

FIRM NAME: White Mortuary 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2742
Local Reg. No. 0-235
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 5 1967 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 505
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place) 5 Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 28 Nebraska
b. COUNTY 555 Kimball
c. CITY OR TOWN Dix
d. STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle) 143	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	EDNA	CAROLYN	GORMAN	June 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Oct. 9, 1891	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Sidney, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William F. Krueger	Germany	Anna Lucas	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	508-26-8920	Jesse L. Gorman	RFD # 3 Buhl, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH 1/2 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Congestive Heart Failure (prob. 2-3 wks)

DUE TO (c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-8, 1967, *to* 6-8-67 19___, *that I last saw the deceased alive on* June 8, 1967, *and that death occurred at* 10:45 P. m.; *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm H Anderson MD	OH	Buhl, Ida	6-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Transportation	6/9/67		Sidney, Nebraska

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6/30/67	Vera Ryals	Robert R. Dickard	E-312

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2743
Local Reg. No. D-233
Reg. Dist. No. 46

BIRTH NO.

RECEIVED JUL 5 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 TWIN FALLS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TWIN FALLS.
c. LENGTH OF STAY (in this place) 10 DAYS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) TWINN FALLS MEM. HOSP. 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 430 TWIN FALLS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BUHL.
d. STREET ADDRESS (If rural, give location) 651 SO. BROADWAY

3. NAME OF DECEASED (Type or Print): a. (First) PAUL b. (Middle) R. c. (Last) CLINE

4. DATE OF DEATH: (Month) JUNE (Day) 8, (Year) 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED 4

8. DATE OF BIRTH: July 24, 1909

9. AGE (In years last birthday) 57 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SERVICE STATION

10b. KIND OF BUSINESS OR INDUSTRY: OPERATOR

11. BIRTHPLACE (State or foreign country): MINNEAPOLIS KANSAS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: BURTON C. CLINE — BIRTHPLACE: KANSAS

14. MOTHER'S MAIDEN NAME: BESSIE BAINS — BIRTHPLACE: UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-09-9232

17. INFORMANT'S OWN SIGNATURE: Johnnie R Cline ADDRESS: Box 577 Centralia Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1637 Metastatic CA of lung — INTERVAL BETWEEN ONSET AND DEATH: weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adeno CA of lungs — months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 25, 1962 *to* June 8, 1967, *that I last saw the deceased alive on* June 8, 1967, *and that death occurred at* 3:10 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 118 (Degree or title) MD

23b. ADDRESS: 122 9th Ave No Buhl

23c. DATE SIGNED: 6-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3

24b. DATE: 6/12/1967

24c. NAME OF CEMETERY OR CREMATORY: [redacted] BUHL

24d. LOCATION (City, town, or county) (State): TWIN FALLS CO. IDAHO.

DATE REC'D BY LOCAL REG.: 6/30/67

REGISTRAR'S SIGNATURE: Vera Ryals

25. EMBALMER: J. Forrest Meany

LICENSE NO.: E 353

FIRM NAME: Meany Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2744
Local Reg. No. D-217
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED JUN 23 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 5 Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rural--7 Miles N. W. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) Olson Apartments

3. NAME OF DECEASED (Type or Print)
a. (First) HARRY b. (Middle) C. c. (Last) TURNER

4. DATE OF DEATH (Month) (Day) (Year) June 9, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH July 6, 1893
9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Livestock
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Henry Turner BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Tessie Hurst BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 520-22-3507
17. INFORMANT'S OWN SIGNATURE Box 2 Leah R. Turner ADDRESS Star Idaho

18. CAUSE OF DEATH 3220
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Alcoholic Poisoning — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Investigationonly, 19__, *to* __, 19__, *that I last saw the deceased alive on* Never, 19__, *and that death occurred at* 10 p m., *from the causes and on the date stated above.*

23a. SIGNATURE H. Thad Scholer 583 (Degree or title) Twin Falls County Coroner 4
23b. ADDRESS 120 Adams St. Twin Falls, Idaho
23c. DATE SIGNED 6/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/14/67
24c. NAME OF CEMETERY OR CREMATORY Buhl
24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. 6-21-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Robert F. Dickard
LICENSE NO. E-312

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2745
Local Reg. No. D-214
Reg. Dist. No. 460

RECEIVED
JUN 16 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 421 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 318 No. Washington

3. NAME OF DECEASED (Type or Print) a. (First) LARRY b. (Middle) JOE c. (Last) MORAN

4. DATE OF DEATH (Month) (Day) (Year) June 10, 1967

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH June 10, 1943

9. AGE (In years last birthday) 24 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 06

10b. KIND OF BUSINESS OR INDUSTRY Pump Co.

11. BIRTHPLACE (State or foreign country) Couer d'Alene, Idaho

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Wm. J. Moran BIRTHPLACE Muldoon, Idaho

14. MOTHER'S MAIDEN NAME Lillian Diethelm BIRTHPLACE Clarkston, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-48-7759

17. INFORMANT'S OWN SIGNATURE Elaine J. Moran ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8151

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MASSIVE BLOOD LOSS — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) THORACIC AORTIC DISRUPTION
DUE TO (c) MOTORCYCLE ACCIDENT

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [4] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE Motorcycle accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Eastland & Kimberly Rd.

21c. (CITY, TOWN, OR TOWNSHIP) Twin Falls 13 (COUNTY) 421 Twin Falls (STATE) Idaho

21d. TIME OF INJURY (Month) 6 (Day) 10 (Year) 67 (Hour) 10 p.m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR? motorcycle & pickup accident

22. *I hereby certify that I attended the deceased from* 6/10, 19 67, to 6/10, 19 67, *that I last saw the deceased alive on* 6, 10, 19 67, *and that death occurred at* 1155 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE John M. McKay 678 (Degree or title) MD

23b. ADDRESS 676 Sixth S

23c. DATE SIGNED 6/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Buried

24b. DATE June 14, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park Cem.

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 6-14-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER

LICENSE NO. E-343

FIRM NAME WHITE MORTUARY Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 19 1967

JUL 11 1967

JUL 26 1967

JUL 25 1988

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2746
Local Reg. No. 272
Reg. Dist. No. 460

RECEIVED JUN 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 / Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rural Route #3 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42 / Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) Rural Route #3

3. NAME OF DECEASED (Type or Print)
a. (First) HOWARD
b. (Middle) GORDON
c. (Last) HILLS

4. DATE OF DEATH (Month) (Day) (Year) June 10, 1967

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 26, 1894

9. AGE (In years last birthday) 72
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Aberdeen, South Dakota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Parker Hills
BIRTHPLACE New Hampshire

14. MOTHER'S MAIDEN NAME Mary Hazelton Abbott
BIRTHPLACE New Hampshire

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES
(If yes, give war or dates of service) WWI

16. SOCIAL SECURITY NO. 518-36-6475

17. INFORMANT'S OWN SIGNATURE Gladys Hills ADDRESS Rt. #3 Twin Falls

4767

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH several months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Old Rh. Heart Disease - Mitral & Aortic Insufficiency — 5 yrs -
DUE TO (c) Cardiomegaly - — 10 yrs -

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-1, 1962, *to* 6-10, 1967, *that I last saw the deceased alive on* 4-24, 1967, *and that death occurred at* 8:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE D. L. McCluskey 333 (Degree or title)

23b. ADDRESS Twin Falls Idaho

23c. DATE SIGNED 6-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE June 13, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. 6-14-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER [signature]
LICENSE NO. E-343

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 13 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 14 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2747
Local Reg. No. D-209
Reg. Dist. No. 460

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUN 16 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 1343 7th Ave. E.

3. NAME OF DECEASED (Type or Print)
a. (First) JACK
b. (Middle) WILLIAM
c. (Last) ELDREDGE

4. DATE OF DEATH (Month) (Day) (Year) June 11, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH April 22, 1951
9. AGE (In years last birthday) 16 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Clarence C. Eldredge — BIRTHPLACE Worland, Wyo.
14. MOTHER'S MAIDEN NAME Esther ruth Brunsdale — BIRTHPLACE Burdett, Alberta ~~Canada~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no 518-62 4674 X
17. INFORMANT'S OWN SIGNATURE Clarence C. Eldredge — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7542

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Complete Heart Block c A-V dissociation — INTERVAL BETWEEN ONSET AND DEATH: 1 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Congenital heart disease — 16 years
① Coarctation
② Atrial septal defect
DUE TO (c) ③ Ventricular septal defect

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Pulmonary hypertension

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/10, 1967, *to* 6/11, 1967, *that I last saw the deceased alive on* 6/11, 1967, *and that death occurred at* 4:40 a *m., from the causes and on the date stated above.*

23a. SIGNATURE S. M. Myhre 576 (Degree or title) MD
23b. ADDRESS 676 Shoup W Twin Falls
23c. DATE SIGNED 6/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Declo Cemetery
24d. LOCATION (City, town, or county) (State) Declo, Idaho

DATE REC'D BY LOCAL REG. 6-14-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. 343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY Twin Falls, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2748
Local Reg. No. D-211
Reg. Dist. No. 460

Certificate of Death

RECEIVED
JUN 16 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
d. STREET ADDRESS (If rural, give location) 875 Yakima Street

3. NAME OF DECEASED (Type or Print)
a. (First) CHARLES
b. (Middle) B.
c. (Last) SHAFF

4. DATE OF DEATH (Month) (Day) (Year) June 11, 1967

5. SEX Male
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 5, 1896
9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Fredrick Shaff — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Edna Backus — BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-42-6163-A
17. INFORMANT'S OWN SIGNATURE * Ella B. Shaff — ADDRESS Filer, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease c̄ multiple episode
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b)
~~DUE TO (c)~~ of myocardial Infarctions

INTERVAL BETWEEN ONSET AND DEATH: 16 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-14, 1960, *to* 6-10, 1967, *that I last saw the deceased alive on* 6-10, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE C F Winster MD 578 (Degree or title)
23b. ADDRESS 204 4th Ave. East Twin Falls, Idaho 83301
23c. DATE SIGNED 6-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 6-14-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

JUN 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2749
Local Reg. No. D-210
Reg. Dist. No. 460

RECEIVED JUN 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 027 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16
b. COUNTY Twin Falls 083
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
d. STREET ADDRESS (If rural, give location) Monroe St. W.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	STELLA	B.	BLADES	June 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	widowed 2	April 21, 1890	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hswf. 07
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Billings, Missouri
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Conrad — BIRTHPLACE Unk.
14. MOTHER'S MAIDEN NAME Hattie Strawn — BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-30-7634A
17. INFORMANT'S OWN SIGNATURE Mrs Raymond Pathridge — ADDRESS Kimberly Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 4 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) a Benign Hypertension — 15 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 6 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-13, 1958, *to* 6-12, 1967, *that I last saw the deceased alive on* 6-12, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. W. Nusbaum M.D.	204 4th Ave. East Twin Falls, Idaho	6-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 15, 1967	Sunset Mem. Park Cem.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-14-67	Pamela J. Johnson	Burke Eden — White Mortuary FIRM NAME: Twin Falls, Idaho	343

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 2 1974

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2750
Local Reg. No. D-215
Reg. Dist. No. 460

BIRTH NO. [illegible]

RECEIVED JUN 23 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 22/ Twin Falls 201
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (In this place) 3 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) J.F. Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 16/ Cassai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 737 West Eighteenth St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Alice	Peterson	Williams	June 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Feb 8, 1917	50				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Ridgedale, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph F. Peterson	Hyrum, Utah	Hannah Spence	Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	x x x		Jerry A Williams	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1208 Carcinoma of the Breast — INTERVAL BETWEEN ONSET AND DEATH: 10½ yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) With Widespread Metastasis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from Feb 19 66 to June, 67, that I last saw the deceased alive on June 12, 19 67 and that death occurred at 90 m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ione C. Hay M.D. 655		711 6th Ave Twin Falls	6-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	6/15/1967	Malad City Cemetery	Malad, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-19-67	Pamela J Johnson	Dantha Payne	E 389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 27 1985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 23 1992

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2751
Local Reg. No. D-216
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUN 23 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42 / Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls Bureau
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42 / b. COUNTY Twin Falls
c. CITY OR TOWN (If outside limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 670 So. Oak

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Silas	Reuben	Mason	June 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married 3	Feb. 18, 1905	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Agriculture	Warrensburg, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard Mason	Missouri	Minnie Ebby	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 30 1086	X Mrs. Althea Mason	Twin Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1637

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Lung — INTERVAL BETWEEN ONSET AND DEATH: Dunk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12 June, 1967, *to* 14 June, 1967, *that I last saw the deceased alive on* 14 June, 1967, *and that death occurred at* 4:05p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James H. Stafford	489 M.D.	Twin Falls, Idaho	6/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 17, 1967	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-19-67	Pamela J. Johnson	W. L. Hove	E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2752
Local Reg. No. 12-319
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls JUN 27 1967 000
b. CITY OR TOWN Twin Falls Bureau of Vital Statistics c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Hosp. 43

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS 1642 Imes Ave (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) ADA b. (Middle) M. c. (Last) LUNDIN

4. DATE OF DEATH (Month) (Day) (Year) June 16, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH May 1, 1885

9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Topeka, Kansas

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Elphrite Foster BIRTHPLACE Indiana

14. MOTHER'S MAIDEN NAME Charlotte Lang BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 518 14 2314

17. INFORMANT'S OWN SIGNATURE John L. Lundin ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral vascular disease — INTERVAL BETWEEN ONSET AND DEATH 4 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒ XXX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 6, 1941, *to* June 16, 1967, *that I last saw the deceased alive on* June 16 1967, *and that death occurred at* 9:31P. m., *from the causes and on the date stated above.*

23a. SIGNATURE Dean H Coffee 003 (Degree or title)

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 6.19.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 6.20.1967

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 6-22-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER

LICENSE NO. 343

FIRM NAME White Mortuary - Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

JUN 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2753
Local Reg. No. D-225
Reg. Dist. No. 460

RECEIVED JUN 30 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 438
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 38 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) R.F.D. # 1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) R.F.D. # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HARMON	FREMONT	EASTERDAY	June 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 19, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Eustis, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alvin Easterday	Ohio	Martha Harmon	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-42-5599	Vera Easterday	RFD # 1 Buhl

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* — *19*—, *to* —, *19*—, *that I last saw the deceased alive on* —, *19*—, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O.R. Cullins MD	1122 9th Ave No Buhl	6-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6/21/67	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-26-67	Pamela J. Johnson	George Farmer	E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

JUN 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 6 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2754
Local Reg. No. D-234
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 420 Twin Falls 105

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl

c. LENGTH OF STAY (in this place) 5 years

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho b. COUNTY 420 Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl

d. STREET ADDRESS (If rural, give location) R.F.D. # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARGARET		RINGERT	June 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	June 27, 1872	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	Own Home	Machias, New York	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lathrop Vinton	New York	Phoebe Morris	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-54-0783	Fred Ringert RFD # 1	Buhl, Idaho

4200

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10-20 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Senility & Heart Failure — 1wk

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Bilat. Nephrolithiasis — 10yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 19 64 p, *to* June 18, 19 67 *that I last saw the deceased alive on* June 17, 19 67, *and that death occurred at* 1:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern H Anderson	MD	Buhl, Idaho	6-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	5/21/67	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6/30/67	Vera Ryals	Robert T. Dickard	E-312

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 10 1978

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2755
Local Reg. No. 2227
Reg. Dist. No. 460

Certificate of Death

RECEIVED
JUN 30 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem.Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
d. STREET ADDRESS (If rural, give location) P.O.Box 82

3. NAME OF DECEASED (Type or Print)
a. (First) RUBEN
b. (Middle) D.
c. (Last) PERKINS

4. DATE OF DEATH (Month) (Day) (Year) June 19,1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 30,1887
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Little River,Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin L.Perkins — BIRTHPLACE Gentry Co.,Missouri
14. MOTHER'S MAIDEN NAME Lorana M.Sloan — BIRTHPLACE Gentry Co.,Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 707-09-6407
17. INFORMANT'S OWN SIGNATURE Kimberly, Mrs Rube Perkins — ADDRESS Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Carcinomatosis - Primary Prostate — 6 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1952, *to* 6/19/67, 1967, *that I last saw the deceased alive on* 6-19, 1967, *and that death occurred at* 2:30a. m., *from the causes and on the date stated above.*

23a. SIGNATURE O. Ellis King 286 (Degree or title) M.D.
23b. ADDRESS Kimberly,Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/21/67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls,Idaho

DATE REC'D BY LOCAL REG. 6-26-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER James C. Reynolds — LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2756
Local Reg. No. 0-220
Reg. Dist. No. 460

RECEIVED JUN 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Twin Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Snake River Reservior above 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
d. STREET ADDRESS (If rural, give location) Twin Falls/ 103 Yakima

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	Gary	Andrews	June	19,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	Cauc.	single	Nov. 22, 1949	17				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Buffalo, New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME David O. Andrews BIRTHPLACE Seldon, Kansas
14. MOTHER'S MAIDEN NAME Betty Schlau BIRTHPLACE Buffalo, New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-60-7873
17. INFORMANT'S OWN SIGNATURE David O Andrews ADDRESS Filer, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9298

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH: 20 min.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident /	Snake River	Twin Falls 13	Twin Falls 42	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Drowned while swimming

22. *I hereby certify that I attended the deceased from* Investigation Only, 19—, *to* —, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* — m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.
23b. ADDRESS 120 Adams, Twin Falls
23c. DATE SIGNED 6-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
burial	6-22-67	Filer IOOF Cemetery	Filer,	Idaho

DATE REC'D BY LOCAL REG. 6-22-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER
LICENSE NO. 343
FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. [ICA 38-206 and 215.] Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

6600

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2757
Local Reg. No. D-218
Reg. Dist. No. 460

BIRTH NO.

JUN 27 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 295 SunnyView Courts

3. NAME OF DECEASED (Type or Print)
a. (First) MABEL
b. (Middle)
c. (Last) STALEY

4. DATE OF DEATH (Month) June, (Day) 19, (Year) 1967

5. SEX female
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Jan. 14, 1893
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook 01
10b. KIND OF BUSINESS OR INDUSTRY restaurant
11. BIRTHPLACE (State or foreign country) Raymond, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Knute Harbolt — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Martha Harryman — BIRTHPLACE Elk Falls, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 562-36-2949-A
17. INFORMANT'S OWN SIGNATURE X Betty J Freeman — ADDRESS 1426 Falls Ave. Twin Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH 7 DAYS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) HYPERTENSIVE CARDIO-VASCULAR DISEASE
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. CORONARY OCCLUSION

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/7/ *, 19* 67 *, to* 6/19/ *, 19* 67 *, that I last saw the deceased alive on* 6/19 *, 19* 67 *, and that death occurred at* 3:10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE V. V. Pulford 525 (Degree or title) MD.
23b. ADDRESS 153 Blue Lakes Blv'd North, T.F.
23c. DATE SIGNED 6/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 21, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) Twin Falls, (State) Idaho

DATE REC'D BY LOCAL REG. 6-22-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. 343

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: WHITE MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2758
Local Reg. No. 12-223
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUN 27 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 312 East Ave. "B"

3. NAME OF DECEASED (Type or Print)
a. (First) ANN
b. (Middle) S.
c. (Last) HARTSHORN

4. DATE OF DEATH (Month) (Day) (Year) June 20, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 18, 1891
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Cherokee, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James M. Smith — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Sarah Riley — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 22 7644
17. INFORMANT'S OWN SIGNATURE X James W. Smith — ADDRESS Twin Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

451X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Abdominal — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aortic aneurysm with rupture. — 2 weeks.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease — ?

19a. DATE OF OPERATION June 19 1967
19b. MAJOR FINDINGS OF OPERATION As above -
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18, 19 67 *to* 6-20, 19 67, *that I last saw the deceased alive on* 6-19, 19 67, *and that death occurred at* 8:02a *m., from the causes and on the date stated above.*

23a. SIGNATURE B. L. Kreilhamp M.D. 296 (Degree or title) 1
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 6/22/67.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 23, 1967
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. 6-23-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 27 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2759
Local Reg. No. D-221
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUN 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 45 Twin Falls 000
b. CITY OR TOWN: Twin Falls
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Memorial Hospital
3d. STREET ADDRESS (If rural, give location): Route #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 270 b. COUNTY: Jerome
c. CITY OR TOWN: Eden

3. NAME OF DECEASED (Type or Print): a. (First) Jesse b. (Middle) W. c. (Last) Willis

4. DATE OF DEATH: (Month) June (Day) 20, (Year) 1967

5. SEX: male

6. COLOR OR RACE: cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Dec. 16, 1890

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Gila Bend, Arizona

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry T. Willis BIRTHPLACE: Cedar City, Utah

14. MOTHER'S MAIDEN NAME: Kathleen Dykes BIRTHPLACE: Auburn, Placer Co., Calif

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-01-9797-A

17. INFORMANT'S OWN SIGNATURE: Mrs Jesse Willis ADDRESS: Eden, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 5371

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cor pulmonale
DUE TO (c) Severe pulmonary emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-28, 1960, *to* June 20, 1967, *that I last saw the deceased alive on* June 20, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. W. Kendall MD

23b. ADDRESS: 206 Martin, Twin Falls, Idaho

23c. DATE SIGNED: 6-22-1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: June 23, 1967

24c. NAME OF CEMETERY OR CREMATORY: Hazelton Cemetery

24d. LOCATION (City, town, or county) (State): Hazelton Idaho

DATE REC'D BY LOCAL REG.: 6-22-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: [signature]

LICENSE NO.: 343

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 20 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2760
Local Reg. No. 12-224
Reg. Dist. No. 460

67-6023

RECEIVED
JUN 27 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 421 T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 1596 9th Avenue East

3. NAME OF DECEASED (Type or Print)
a. (First) DALE
b. (Middle) LYNN
c. (Last) GOODWIN

4. DATE OF DEATH (Month) (Day) (Year) June 20, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 1
8. DATE OF BIRTH June 16, 1967
9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR: Months 0, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ralph Goodwin — BIRTHPLACE Ramsey, Iowa
14. MOTHER'S MAIDEN NAME Judith Jones — BIRTHPLACE Picher, Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Judith Goodwin — ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

583X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Infarct of liver — INTERVAL BETWEEN ONSET AND DEATH 4 days
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ~ Hypoprothrombinemia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Hemorrhage — 2 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/17, 1967, *to* 6/20/, 1967, *that I last saw the deceased alive on* 6/20, 1967, *and that death occurred at* 7:53 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 576 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 6-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/22/67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 6-23-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Paul B. Reynolds — LICENSE NO. E-495
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED
JUN 30 1967
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2761
Local Reg. No. D-226
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. VENOTE OR STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Corner of Harrison & Falls Ave 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Twin Falls
d. STREET ADDRESS (If rural, give location) R.R.#2

3. NAME OF DECEASED (Type or Print)
a. (First) HERBERT
b. (Middle) H.
c. (Last) THOMAS

4. DATE OF DEATH (Month) (Day) (Year) June 22, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH August 8, 1908
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Danbury, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur Thomas — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Rozella Carson — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 520-01-3355
17. INFORMANT'S OWN SIGNATURE Mrs. Herbert H. Thomas — ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9023

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Depressed Skull Fracture — instant
DUE TO (c) Fall of 33 feet

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) New Construction 20
21c. (CITY, TOWN, OR TOWNSHIP) Twin Falls 13 — (COUNTY) Twin Falls 421 — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 22, 1967 10:15 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Cement wall caved in causing fall of 33 feet

22. *I hereby certify that I attended the deceased from* Coroner's Investigation only, *to* ____, *19*____, *that I last saw the deceased alive on* ____, *19*____, *and that death occurred at* 10:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE H. Thad Scholes M.D. 583 (Degree or title) Coroner 4
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 6/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6/27/67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 6-26-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Paul D. Reynolds — Paul D. Reynolds
LICENSE NO. E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2762
Local Reg. No. D-232
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LOUISE	JANE	HAMILTON	June 23 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	white	widowed 2	Sept 19, 1890	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Canton, Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel James McCarthy	New York	Catherine Murray	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			L. J. Hamilton	Buhl, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Malignant lymphoma	years
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Hypertension	years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 2, 1961, *to* June 23, 1967, *that I last saw the deceased alive on* June 23, 1967, *and that death occurred at* 12:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	1229 4th Ave No Buhl	6-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	June 27, 1967	Buhl Cemetery	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6/30/67	Vera Ryals	George Farmer	E-480

FIRM NAME: Albertson-Pickard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2763
Local Reg. No. 0-229
Reg. Dist. No. 46a

BIRTH NO.

RECEIVED JUL 5 1967 Vital Statistics Bureau of Health

1. PLACE OF DEATH
a. COUNTY Twin Falls 42
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place) ½ days
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Hosp. 43

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer (rural)
d. STREET ADDRESS (If rural, give location) Route # 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ANNA		HONDERICH	June 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 3	Feb. 21, 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Middlebury, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gideon Yoder	Indiana	Mary Miller	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	Mrs Harold (Naomi) Hooley	Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest + pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 36 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic Heart disease unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-21-67 *to* 6-23, 1967, *that I last saw the deceased alive on* 6-22, 1967, *and that death occurred at* 5:00a m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Harry F. Brumbach 064 (Degree or title) MD	Twin Falls, Idaho	6-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	6-26-67	Kohlerlawn Cemetery	Nampa, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6/29/67	Vera Ryals	Dale Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 5 1967 Bureau of Vital Statistics

State File No. 2764 D 238
Local Reg. No.
Reg. Dist. No. 460

BIRTH NO.

Inform, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. Use BLACK ink or typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42 158
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 58 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 43

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 42
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 325 8th Ave. E.

3. NAME OF DECEASED (Type or Print): a. (First) GOLDIE b. (Middle) MARIE c. (Last) GRIMES

4. DATE OF DEATH (Month) (Day) (Year): June 24, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 28, 1889

9. AGE (In years last birthday): 78 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): New Carlyle, Indiana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Christian F. Jauch — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Grace — BIRTHPLACE: Bovaria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: 518-18-5502

17. INFORMANT'S OWN SIGNATURE: x Hazel L. Ostrander — ADDRESS: Twin Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Arteriosclerosis — 6 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-19- , 19 65, *to* 6-24 , 19 67, *that I last saw the deceased alive on* 1-19- , 19 67 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): M.D.

23b. ADDRESS: 204 4th Ave. East, Twin Falls, Idaho 83301

23c. DATE SIGNED: 6-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: June 26, 1967

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 6/29/67

REGISTRAR'S SIGNATURE: Vera Ryals

25. EMBALMER

LICENSE NO.: 343

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-65021

APR 18 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. D-231 2765
Local Reg. No.
Reg. Dist. No. 46.0

BIRTH NO.

RECEIVED JUL 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Murphy Hot Springs Owyhee
d. STREET ADDRESS (If rural, give location) Rogerson, Idaho
Murphy's Hot Springs

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HUGH	K.	RANKIN	June 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Nov. 5th, 1898	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Resort Owner 23		Pittsburg, Pa.	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hugh K. Rankin Sr.	Unknwn	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	052 07 4235	Charles F. Jonasek	Rogerson, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5811

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cirrhosis of the liver — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic alcoholism — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive Cardiovascular disease — 1 year
Obesity

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2-7- , 19 67 , *to* 6-26- , 19 67 , *that I last saw the deceased alive on* 6-20- , 19 67 , *and that death occurred at* 12:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George S. Brown MD	Twin Falls, Idaho	6.28.67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7.2.67	LiveOak Memorial Park	Monrovia, Calif.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6/29/67	Vera Ryals	Edgar Robertson	E 507

FIRM NAME: White Mortuary-TwinFalls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63001

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2766
Local Reg. No. D-228
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 432 Highland Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 432 Highland Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Steve		Rehay Sr.	June	26	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Widowed 2	February 2, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Farmer 04	Farming	Hasprunt, Czechoslovakia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		542-36-3519	x Virginia Morrow	Twin Falls, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Arteriosclerosis 334X	1 year
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-17, 1962, *to* 6-26, 1967, *that I last saw the deceased alive on* 6-19, 1967, *and that death occurred at* 9:25 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean H. Ashleman M.D.	231 4th Ave. Nth Twin Falls, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-29-67	Glenn Rest Cemetery	Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6/28/67	Vera Ryals	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

67-8136

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2767
Local Reg. No. D-236
Reg. Dist. No. 460

BIRTH NO.

JUL 6 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If outside corporate limits, write RURAL and give township)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 111 Sidney

3. NAME OF DECEASED (Type or Print)
a. (First) Timothy
b. (Middle) Jon
c. (Last) Williams

4. DATE OF DEATH (Month) (Day) (Year) June 28, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH June 27, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 1 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Doyal Williams
BIRTHPLACE Gainesville, Texas
14. MOTHER'S MAIDEN NAME Betty Hall
BIRTHPLACE Darlington, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE x Betty J. Williams
ADDRESS TwinFalls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7735

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Failure

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Prematurity

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 27 June, 1967, *to* 28 June, 1967, *that I last saw the deceased alive on* 28 June, 1967, *and that death occurred at* 3:30 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE W H Kramer 293 (Degree or title) MD-1
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 6.30.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6.30.67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 7-3-67
REGISTRAR'S SIGNATURE Vera Ryals
25. EMBALMER [signature]
LICENSE NO. 343

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2768
Local Reg. No. D-237
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) Statdays
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 364 Blake St. North

3. NAME OF DECEASED (Type or Print) a. (First) VIRGINIA b. (Middle) MARGARET c. (Last) WOHLLAIB

4. DATE OF DEATH (Month) (Day) (Year) June 30, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH May 16, 1902
9. AGE (In years last birthday) 65 | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Richland, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Adolph Benz BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME no record BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY 519-28-0127
17. INFORMANT'S OWN SIGNATURE Wesley J. Wohllaib, Twin Falls, ADDRESS Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis, abdomen, all organs — INTERVAL BETWEEN ONSET AND DEATH: 2 Mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adenacarcimonia, breast — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Diffuse parietal&visceral peritoneal&organ implants
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 7:30p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 758
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 3, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 7-6-67
REGISTRAR'S SIGNATURE
25. EMBALMER
LICENSE NO. E-451
FIRM NAME: TWIN FALLS MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17, to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2769
Local Reg. No. 37
Reg. Dist. No. 310

BIRTH NO.

RECEIVED JUN 14 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley County Hospital 152

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 430 Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RALPH	LESLIE	CALKINS	June 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 5, 1908	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck driver 77	Logging	Sidney, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elmer Calkins	Iowa	Sarah Means	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	508-05-6911	Edna Calkins	Cascade, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

8220

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CONGESTIVE CARDIAC FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 7 DAYS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) RUPTURED PAPILLARY MUSCLE OF HEART — 9 DAYS
DUE TO (c) CARDIAC CONTUSION — 9 DAYS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
ACCIDENT	HIGHWAY 06	CASCADE 13	VALLEY 430	IDA

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☑ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
9 8 66 m.		TRUCK OVERTURNED

22. *I hereby certify that I attended the deceased from* 9/8, 1966, *to* 6/6, 1967, *that I last saw the deceased alive on* 6/6, 1967, *and that death occurred at* 3P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm F. Moore MD	CASCADE, IDA	6/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 9, 1967	Margaret Cemetery	Cascade, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
June-12-1967	Myrtle A. Gardner	Burton E. Walker	E-386

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2770
Local Reg. No. 18
Reg. Dist. No. 310

BIRTH NO.

RECEIVED JUL 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Valley 430
b. CITY OR TOWN: McCall (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: At home in McCall

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Valley 430
c. CITY OR TOWN: McCall (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location): McCall

3. NAME OF DECEASED (Type or Print): a. (First) KIMBERLY b. (Middle) JOAN c. (Last) DAVIS

4. DATE OF DEATH: (Month) June (Day) 14, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: April 3, 1967

9. AGE (In years last birthday): IF UNDER 1 YEAR Months 2 Days 11; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): McCall Idaho

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: G. Dean Davis
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Sandra Joan Rogers
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: A. Dean Davis
ADDRESS: McCall, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7620

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tracheal obstruction — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe brain damage, generalized — 2 mos. Hd.
DUE TO (c) Anoxia neotorum — 2 hrs. 11d.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-3, 1967, *to* 6-14, 1967, *that I last saw the deceased alive on* 6-11, 1967, *and that death occurred at* 6:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wayne F. Allen M.D. (Degree or title)

23b. ADDRESS: McCall Idaho

23c. DATE SIGNED: 6-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6/16/67

24c. NAME OF CEMETERY OR CREMATORY: Glenn Rest Cemetery

24d. LOCATION (City, town, or county) (State): Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.: June 28 1967

REGISTRAR'S SIGNATURE: Mayette M. Gardner

25. EMBALMER: H. Dee Humphreys

LICENSE NO.: E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form OH-63021

DUTIES: D-67-3976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 14 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2771
Local Reg. No. 11
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Valley 430 201
b. CITY OR TOWN McCall
LENGTH OF STAY (in this place) 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 430 Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) ROYAL
b. (Middle) BENGERMINA
c. (Last) COPELAND

4. DATE OF DEATH (Month) (Day) (Year) June 23, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH June 7, 1883
9. AGE (In years last birthday) 84 | If UNDER 1 YEAR: Months, Days | If UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mining Prospector
10b. KIND OF BUSINESS OR INDUSTRY Oil
11. BIRTHPLACE (State or foreign country) Burns, Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lloyd D. Copeland
BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Ida M. White
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 519-22-5482
17. INFORMANT'S OWN SIGNATURE personal records
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

545X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHOPENEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 6 DAYS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ACUTE AND CHRONIC PYLORIC OBSTRUCTION, CAUSE UNKNOWN.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ARTERIOSCLEROTIC HEART DISEASE WITH CONGESTIVE HEART FAILURE

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JUNE 5, 1967, *to* JUNE 23, 1967, *that I last saw the deceased alive on* JUNE 23, 1967, *and that death occurred at* 11:20 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Gerald S. Mokeen M.D.
23b. ADDRESS McCALL, IDAHO
23c. DATE SIGNED 6-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 28, '67
24c. NAME OF CEMETERY OR CREMATORY McCall Cemetery
24d. LOCATION (City, town, or county) McCall, (State) Idaho

DATE REC'D BY LOCAL REG. July 5-1967
REGISTRAR'S SIGNATURE Myrtle M. Gardner
25. EMBALMER Burton C Walker
LICENSE NO. E 386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2772
Local Reg. No. 132
Reg. Dist. No. 310

RECEIVED JUL 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
LENGTH OF STAY (in this place) 1 Year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011 b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1411 Cottonwood Ct.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Howard	Phillip	Carter	June 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Sept. 17, 1898	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman 08	Boise City Fireman	Brainard, Minn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Carter	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	518-09-5843	Norma M. Carstens	Boise

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute cerebro-vascular accident	2-3 min
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Cerebral arteriosclerosis	10 yrs +
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	He has had several prev. strokes	8 yrs + 2 yrs

331.1

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-18 *, 19*66*, to* 6-23 *, 19*67*, that I last saw the deceased alive on* 6-18 *, 19*67*, and that death occurred at* 4A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James H. Stewart	MD	Cascade Idaho	6-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-27-67	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG. July 8-1967 | REGISTRAR'S SIGNATURE Myrtle M. Gardner

25. EMBALMER Eldon T. Pearson | LICENSE NO. E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2773
Local Reg. No. 73
Reg. Dist. No. 310

RECEIVED JUL 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley 303
b. CITY OR TOWN Cascade
LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley County Hospital 152

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 432 b. COUNTY Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) ELMER b. (Middle) J. c. (Last) HAWKINS

4. DATE OF DEATH (Month) (Day) (Year) June 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	July 21, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mail Carrier 08	U.S. Post Office	Beardsley, Minnesota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
B. D. Hawkins	New York	Carrie Emma Douglas	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-36-2458	Melvina Hawkins	Nampa, Idaho

18. CAUSE OF DEATH 420 1

MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH 72 HRS

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
		CASCADE	VALLEY	IDA

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* MAY, 1958, *to* JUNE, 1967, *that I last saw the deceased alive on* June 25 1967, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John J. Moore 376	MD	CASCADE IDA	7/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	June 28, 1967	Margaret Cemetery	Cascade, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 8 - 1967	Myrtle M Gardner	Burton E Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 24 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 19 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2774
Local Reg. No. 47
Reg. Dist. No. 320

BIRTH NO.

RECEIVED JUN 19 1967 Vital Statistics Bureau of Health

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 624 E. 2nd

3. NAME OF DECEASED (Type or Print): a. (First) NOEL; b. (Middle) RILEY; c. (Last) MOORE

4. DATE OF DEATH: (Month) June (Day) 6 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 6, 1890

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months 11 Days 0
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Realtor

10b. KIND OF BUSINESS OR INDUSTRY: Real Estate

11. BIRTHPLACE (State or foreign country): Weiser, Idaho

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Isaac Moore
BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: Sarah Ann Underhill
BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: E. R. Moore
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Thrombosis
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-5, 1967, *to* 6-6, 1967, *that I last saw the deceased alive on* 6-6, 1967, *and that death occurred at* 11:10 P. m.; *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. O. McGrath MD
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 6/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6/10/1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: 6/7/67
REGISTRAR'S SIGNATURE: R. Dee Thomason
25. EMBALMER: Randolph Dickerson Jr.
LICENSE NO.: E 464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 24 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2775
Local Reg. No. 42
Reg. Dist. No. 310

BIRTH NO.

RECEIVED JUN 19 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY in this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 53 Rte. #4

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Emmett	P.	Schnell	6	12	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caucasian	divorced 4	12/18/1920	46				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 27	Construction	Detroit, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Emmett P. Schnell	----	Marie	------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW 2 4	378-09-9586	Bernard Schnell	Mich. via telephone

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Internal Injuries — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
1	Highway 30	13	Ada	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
June 12, 1967 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Auto Accident

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* 6-12-67, 19____, *and that death occurred at* 5:35 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas R. McDonnell M.D.	Weiser, Idaho	6/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Removal 3	6/15/67	Kohlerlawn Cemetery	Nampa	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6/13/67	R. Dee Thomson	Marshall Dickerson	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 11 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 17 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 18 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2776
Local Reg. No. 44
Reg. Dist. No. 320

BIRTH NO.

RECEIVED JUN 21 1967 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 63 Park Haven

3. NAME OF DECEASED (Type or Print): a. (First) Annabelle; b. (Middle); c. (Last) Morse

4. DATE OF DEATH: (Month) June (Day) 14 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	widowed 2	5/31/1877	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Yale, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ebenezer Culver — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Alice E. Thompson — BIRTHPLACE: -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Caldwell, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic H Dis — 10 yrs
DUE TO (c) Gen. Arteriosclerosis — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebro-vascular accid — 14 hrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/14, 1965, *to* 6/14, 1967, *that I last saw the deceased alive on* 6/14, 1967, *and that death occurred at* 5:35 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 186 (Degree or title)
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 6/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 6/17/67
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest
24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: 6-17-67
REGISTRAR'S SIGNATURE: R. Dale Thomason
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E 464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED JUL 7 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2777
Local Reg. No. 45
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 22/ Washington 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital 133

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 47
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 143 E. Galloway

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Harvey	Milton	Launt	6	20	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caucasian	married 3	11/28/1902	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
plumber 27	plumbing	Oakdale, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William E. Launt	New York	Cassie I. Tompson	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-09-0328	Mrs L. M. Launt	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, Bilat — INTERVAL BETWEEN ONSET AND DEATH: 12h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Respiratory failure — 3½h
DUE TO (c) Cerebro-vascular accident — 6d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Peptic ulcer & hernia — 7d

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
			m.		

22. *I hereby certify that I attended the deceased from* 10/19, 1966, *to* 6/20, 1967, *that I last saw the deceased alive on* 6/20, 1967, *and that death occurred at* 3:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M.D.	Weiser, Idaho	6/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
burial trans	6/23/67	Riverside Cemetery	Payette	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
6-23-67	R. Dale Thomsen	Marshall S. Dickerson Jr.	E 464

FIRM NAME Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 7 1967

APR 18 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 277
Local Reg. No. 398
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 016
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise- Rural
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. St Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 016
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle- Rural
d. STREET ADDRESS (If rural, give location): R# 1

3. NAME OF DECEASED (Type or Print): a. (First) EVA; b. (Middle) LOUISE; c. (Last) GROESBECK

4. DATE OF DEATH: (Month) May (Day) 15, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 16, 1909

9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 07

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Eric La Land — BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Claudia Thuott — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: x Eug Groesbeck — ADDRESS: Eagle, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 5/15/67, 19__, *to* Investigation Only, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 7:10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Larson 583 (Degree or title) Coroner, Ada Co.

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: May 18, 1967

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: 7-26-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Paul Simpson — LICENSE NO.: E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2779
Local Reg. No. 375
Reg. Dist. No. 370

RECEIVED JUL 19 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kuna
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 203 1/2 East 1st. St. Kuna 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kuna
d. STREET ADDRESS (If rural, give location): 203 1/2 East First Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
FRED		KRUEGER	July	1,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	divorced 4	November 2, 1883	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Watchman 08	Bureau of Reclamation	Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Krueger	Germany	Louisa Rudolph	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 07 3003	Marvin H. Krueger	Camas Wash.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Had high Blood pressure. — Months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* 12:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 583	Coroner	3720 Meadow Drive, Boise.	7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 5, 1967	Kuna Cemetery	Kuna Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-17-67	Myrtle Palmer	William R. Wise, Jr.	E-513

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 5 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2780
Local Reg. No. 100
Reg. Dist. No. 371

BIRTH NO. JUL 10 1967

1. PLACE OF DEATH
a. COUNTY: 017 Ada 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Nursing Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 06 Colorado
b. COUNTY: 555 Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Leadville
d. STREET ADDRESS (If rural, give location): Leadville, Colorado

3. NAME OF DECEASED (Type or Print)
a. (First): Linnie
b. (Middle): Myrtle
c. (Last): Reger

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 30, 1870
9. AGE (In years last birthday): 97 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Houswife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Mill Hall Penn.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sol Kryder — BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: No.
17. INFORMANT'S OWN SIGNATURE: Charles C. Reger MD — ADDRESS: Oreg

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Senility — INTERVAL BETWEEN ONSET AND DEATH: 2 years.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September 1, 1965, *to* July 2, 1967, *that I last saw the deceased alive on* June 30, 1967, *and that death occurred at* 1:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Roscoe C Ward 550 (Degree or title) MD
23b. ADDRESS: Boise. Idaho
23c. DATE SIGNED: 7-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 7-4-67
24c. NAME OF CEMETERY OR CREMATORY: Leadville Cemetery
24d. LOCATION (City, town, or county) (State): Leadville, Colorado

DATE REC'D BY LOCAL REG.: 7-10-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Daniel G. Gibson — LICENSE NO.: E-400

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Gibson Funeral Home

DUTIES:

JUL 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2781
Local Reg. No. 350
Reg. Dist. No. 370

BIRTH NO.

JUL 10 1967

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 804 North 9th. Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): St. John's Cathedral

3. NAME OF DECEASED (Type or Print): a. (First) Rev. Fr. b. (Middle) Thomas J. c. (Last) Kelly

4. DATE OF DEATH: (Month) July (Day) 3, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Sept. 8, 1911

9. AGE (In years last birthday): 55 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Priest 18

10b. KIND OF BUSINESS OR INDUSTRY: Catholic Church

11. BIRTHPLACE (State or foreign country): Philadelphia, Penn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Patrick Norris Kelly — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Mary Anne Pyne — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Nicholas V. Hughes — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: rapid

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Joseph H. Lowney MD (Degree or title): 216

23b. ADDRESS: 850 S Latah

23c. DATE SIGNED: 7 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-7-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 7-10-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Daniel G. Gibson — LICENSE NO.: E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 25 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2782
Local Reg. No. 348
Reg. Dist. No. 370

RECEIVED JUL 7 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 01 — 109
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 9 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3606 Berry Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Douglas — b. (Middle) Wesley — c. (Last) Loveland

4. DATE OF DEATH: (Month) 7 (Day) 3 (Year) 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single 1

8. DATE OF BIRTH: 12-14-57

9. AGE (In years last birthday): 9 — IF UNDER 1 YEAR: Months 6, Days 19 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): student 03

10b. KIND OF BUSINESS OR INDUSTRY: - -

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wesley H. Loveland — BIRTHPLACE: Nampa, Idaho

14. MOTHER'S MAIDEN NAME: Elda Gayle Dalton — BIRTHPLACE: Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: - -

17. INFORMANT'S OWN SIGNATURE: x Wesley H. Loveland — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2893

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cystic Fibrosis of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 7yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 7/2, 1967, *that I last saw the deceased alive on* 7/2, 67, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: J C Welch 558 — (Degree or title): MD — **23b. ADDRESS**: 218 N 18th Boise — **23c. DATE SIGNED**: 9/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial — **24b. DATE**: 7-6-67 — **24c. NAME OF CEMETERY OR CREMATORY**: Cloverdale Cemetery — **24d. LOCATION** (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 7-7-67 — **REGISTRAR'S SIGNATURE**: Myrtle Palmer — **25. EMBALMER**: Russell A. Relyea — **LICENSE NO.**: E-412

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2783
Local Reg. No. 99
Reg. Dist. No. 371

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3115 Sycamore Dr.

3. NAME OF DECEASED (Type or Print)
a. (First): Ethel
b. (Middle): May
c. (Last): McClaran

4. DATE OF DEATH (Month) (Day) (Year): July 3, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 6, 1881
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): North Bend, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred Doubrava — BIRTHPLACE: Bohemia
14. MOTHER'S MAIDEN NAME: Willie Goodrich — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Fred A. McClaran — ADDRESS

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteria - sclerotic coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteria, sclerosis — 10 years
DUE TO (c): Hypertension — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1966, *to* July 3, 1967, *that I last saw the deceased alive on* July 1, 1967, *and that death occurred at* 8:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Roscoe C. Ward 550 (Degree or title) MD.
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/6/1967
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens Cem.
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-5-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: John F. Wilkerson
LICENSE NO.: E-435

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McBratney-Alden-Waggoner

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2784
Local Reg. No. 102
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
JUL 14 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE, IDAHO
c. LENGTH OF STAY (in this place): 56 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 517 Blaine Street

3. NAME OF DECEASED (Type or Print): a. (First) Harley; b. (Middle) R; c. (Last) O'NEAL

4. DATE OF DEATH: (Month) 7; (Day) 3; (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: 1-7-12

9. AGE (In years last birthday): 55
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter 21

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Mo.

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Columbus O'Neal
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Evelyn Matthews.
BIRTHPLACE: Unkn[illegible]

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 488 22 7989

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: John O [illegible]
VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

162.1

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 10 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. I attended the deceased from 5-8, 19 67, to 7-3, 19 67, [illegible] and that death occurred at 6:05PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Glenn Q Voyles M.D. 597
GLENN Q VOYLES, M.D.

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 7-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7/6/67

24c. NAME OF CEMETERY OR CREMATORY: Lower Boise Cemetery

24d. LOCATION (City, town, or county) (State): Parma, Idaho

DATE REC'D BY LOCAL REG.: 7-12-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Merville D Davis

LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel Caldwell, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2785
Local Reg. No. 357
Reg. Dist. No. 370

RECEIVED
JUL 17 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print): a. (First) John; b. (Middle); c. (Last) Patten

4. DATE OF DEATH (Month) (Day) (Year): July 3, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 26, 1891

9. AGE (In years last birthday): 75 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor 11

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Manti, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas J. Patten — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Abigail Marker — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-16-7041

17. INFORMANT'S OWN SIGNATURE: X John A. Patten — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease, with heart block, and ventricular fibrillation.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Prostatic hypertrophy, benign. with suprapubic cystotomy for relief of obstruction.

INTERVAL BETWEEN ONSET AND DEATH: years. / years.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12.22, 1965, *to* 7.3, 1967, *that I last saw the deceased alive on* 7.2, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. K. Newcomb, M.D. 387

23b. ADDRESS: 512 N. 16th Street, Boise, Idaho, 83702

23c. DATE SIGNED: 7.6.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 6, 1967

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-12-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: G. W. Waters — LICENSE NO.: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 18 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Seen also in last illness by Dr. John Ocker, and Dr. Walter Hair.

Certificate of Death

STATE OF IDAHO

State File No. 2786
Local Reg. No. 101
Reg. Dist. No. 371

RECEIVED JUL 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho.
LENGTH OF STAY (in this place) 28 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 300 b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
d. STREET ADDRESS (If rural, give location) P.O. Box 1352.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Clarence	J	OBERLIN.	7	3	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	2-5-92	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer. 06
10b. KIND OF BUSINESS OR INDUSTRY Same
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Oliver O Oberlin. BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Sarah Palpin BIRTHPLACE Ia.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1
16. SOCIAL SECURITY NO. 516 09 78 78
17. INFORMANT'S OWN SIGNATURE John D. Locke ADDRESS VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

491X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease — 4 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-5, 19 67, to 7-3, 1967, and that death occurred at 6:10PM m., from the causes and on the date stated above.

23a. SIGNATURE Glenn Voyles (Degree or title) GLENN O VOYLES, M.D. 594-597 1
23b. ADDRESS VA CENTER, BOISE IDAHO
23c. DATE SIGNED 7-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE July 7, 1967
24c. NAME OF CEMETERY OR CREMATORY Willamette Nat. Cemetery
24d. LOCATION (City, town, or county) Portland (State) Oregon

DATE REC'D BY LOCAL REG. 7-10-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Eldon T. Pearson Eldon T. Pearson LICENSE NO. E-512
FIRM NAME: GIBSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, I

AUG 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2787
Local Reg. No. 349
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 10 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place): 7 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN: Boise
d. STREET ADDRESS: 1920 West State Street

3. NAME OF DECEASED (Type or Print): a. (First) SHERMAN b. (Middle) N. c. (Last) WEISGERBER

4. DATE OF DEATH: July 4, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Oct. 4, 1891

9. AGE (In years last birthday): 75

IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Superintendent

10b. KIND OF BUSINESS OR INDUSTRY: highway construction

11. BIRTHPLACE (State or foreign country): Knoxville, Tennessee

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William F. Weisgerber, BIRTHPLACE: Knoxville, Tenn.

14. MOTHER'S MAIDEN NAME: Mabelle Hickman, BIRTHPLACE: Knoxville, Tenn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 519-01-0901

17. INFORMANT'S OWN SIGNATURE, ADDRESS: Mrs Olive Weisgerber, Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction (6hr) — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery atherosclerosis
DUE TO (c) Coronary artery Thrombosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Interstitial Edema

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 63, *to* July 4 67, *that I last saw the deceased alive on* July 4, 1967, *and that death occurred at* 5:50 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John E. Carpenter MD 044

23b. ADDRESS: 1311 Idaho St

23c. DATE SIGNED: 7-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-7-67

24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-10-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: F. Willard Reed

LICENSE NO.: E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 2 9 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2788
Local Reg. No. 360
Reg. Dist. No. 370

RECEIVED JUL 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada (011)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (Hospital or institution): 3½ Months (332)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada (001)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1931 North 20th Street

3. NAME OF DECEASED (Type or Print)
a. (First): PEARL
b. (Middle): ANN
c. (Last): JONES

4. DATE OF DEATH (Month) (Day) (Year): July 4, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married (3)
8. DATE OF BIRTH: Dec. 18, 1910
9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (01)
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): McKenzie, North Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hans Larson
BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Anna Nelson
BIRTHPLACE: Denmark, Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Alfred B Jones
ADDRESS: 1931 N. 20th Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 1708 Metastatic Carcinoma breast — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3-6, 1967, *to* July 4 1967, *that I last saw the deceased alive on* July 2, 1967, *and that death occurred at* 1:30 AM *from the causes and on the date stated above.*

23a. SIGNATURE: George R Baker MD 019 (Degree or title)
23b. ADDRESS: 1121 E. Idaho Boise
23c. DATE SIGNED: 7-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-6-67
24c. NAME OF CEMETERY OR CREMATORY: Star Cemetery
24d. LOCATION (City, town, or county) (State): Star, Idaho

DATE REC'D BY LOCAL REG.: 7-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: F. Richard Reed
LICENSE NO.: E-440
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2789
Local Reg. No. 345
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 10 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1503 Broadway 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1503 Broadway

3. NAME OF DECEASED (Type or Print)
a. (First): Bernard
b. (Middle): J.
c. (Last): Weis

4. DATE OF DEATH (Month) (Day) (Year): July 4, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 27, 1898
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Admin. Assistant 35
10b. KIND OF BUSINESS OR INDUSTRY: M. K.
11. BIRTHPLACE (State or foreign country): McKeesport, Penn.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Robert L. Hammersley — ADDRESS: Boise

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Was recent17 in Hospital for Heart treatment. had collapsed in a cafe early that Morning. — Months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris 583 (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: 7-6-67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-6-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-6-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Daniel G. Gibson — LICENSE NO.: E-400
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 9 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2790
Local Reg. No. 363
Reg. Dist. No. 370

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 13 1967 Bureau of V

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6604 Lakeside Drive 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6604 Lakeside Drive

3. NAME OF DECEASED (Type or Print)
a. (First): WALLACE
b. (Middle): EDWARD
c. (Last): McGOLDEN

4. DATE OF DEATH (Month) (Day) (Year): July 5, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 7, 1916
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 08
10b. KIND OF BUSINESS OR INDUSTRY: U. S. Government
11. BIRTHPLACE (State or foreign country): Waynoka, Woods, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Marion Arthur McGolden
BIRTHPLACE: Solomon Rapids Kansas
14. MOTHER'S MAIDEN NAME: Laura Duncan
BIRTHPLACE: Edmond, Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes 10-9-36 10-11-40
16. SOCIAL SECURITY NO.: 519-50-5316
17. INFORMANT'S OWN SIGNATURE: Mrs Audrey McGolden (W. E.)
ADDRESS: 6604 Lakeside Boise, Ida

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic coronary thrombosis — "
DUE TO (c): coronary arteriosclerosis — years —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 27 JAN, 1966, *to* 5 July, 1967, *that I last saw the deceased alive on* 29 June, 1967, *and that death occurred at* 10:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: J Hugh Atchley 014 (Degree or title) MD
23b. ADDRESS: 401 Idaho St Boise Ida.
23c. DATE SIGNED: 10 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-8-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Dowell Demaray
LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2791
Local Reg. No. 351
Reg. Dist. No. 370

BIRTH NO. JUL 10 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 011 Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1009 North 19th.

3. NAME OF DECEASED (Type or Print) a. (First) Georgie b. (Middle) Cummings c. (Last) Way

4. DATE OF DEATH (Month) (Day) (Year) July 5, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Nov. 7, 1876

9. AGE (In years last birthday) 90
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Philadelphia, Penn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank William Cummins BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Fanne Anne Amelia Lear BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-07-8391-B

17. INFORMANT'S OWN SIGNATURE Wade F. Walden ADDRESS Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) (1) Rupture of aortic aneurysm

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: a few mins. several yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-14, 1950, *to* 7-5, 1967, *that I last saw the deceased alive on* 6-27, 1967, *and that death occurred at* 4:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE Paul F. Miner 364 (Degree or title) M.D.

23b. ADDRESS 105 N. 8th St. Boise Idaho

23c. DATE SIGNED 7/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-7-67

24c. NAME OF CEMETERY OR CREMATORY Morris Hill

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 7-10-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Daniel G. Gibson

LICENSE NO. E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JUL 17 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2792
Local Reg. No. 369
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 117
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 17 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital, Boise 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Ida ho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3209 Davis St.

3. NAME OF DECEASED (Type or Print)
a. (First): Louise
b. (Middle): Marie
c. (Last): Potter

4. DATE OF DEATH (Month) (Day) (Year): 7- 5- 67

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: 7-26-03
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months 11, Days 9 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: - -
11. BIRTHPLACE (State or foreign country): Florence, Ariz.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Pierson — BIRTHPLACE: Paris, France
14. MOTHER'S MAIDEN NAME: Alice Bigley — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: - -
17. INFORMANT'S OWN SIGNATURE: Raymond Potter — ADDRESS: 3209 Davis, Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5721

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Bacteremic Shock. — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Pelvic Abscess. — 2 wk
DUE TO (c): Ruptured Diverticulum — 2 wks.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Rheumatoid Arthritis. — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-14, 1967, *to* 7-5, 1967, *that I last saw the deceased alive on* 7-5, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 318 [illegible] 1
23b. ADDRESS: 401 Dorchard Boise Ida
23c. DATE SIGNED: 7/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 7-8-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 7-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Russell A. Relyea
LICENSE NO.: E-412
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit only after receiving a completed certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2793
Local Reg. No. 104
Reg. Dist. No. 371

RECEIVED JUL 14 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
LENGTH OF STAY (in this place): 170 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 2312 N. 25th St. Boise, Idaho.
d. STREET ADDRESS (If rural, give location): 2312 N. 25th St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Robert	W	YOUNGMAN.	7	6	67.

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	8-5-23	43				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rt. Man. Soft Water. Co.
10b. KIND OF BUSINESS OR INDUSTRY: 09 Same
11. BIRTHPLACE (State or foreign country): Iowa.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Ralph Youngman. BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Ida Phillippi. BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II 42 1621
16. SOCIAL SECURITY NO.: 484 12 5594
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchogenic carcinoma lung with osseous and adrenal metastases. — INTERVAL BETWEEN ONSET AND DEATH: 1 Year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Recent dorsal chordotomy — 3 Days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
See 19b	10/3/66-Bronchogenic carcinoma LUL 2/23/67 Metastatic bronchogenic carcinoma, right femur 7-3-67 Chordotomy	YES XXX NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I last attended the deceased from 1-18, 1967, to 7-6, 19 67, and that death occurred at 2:30AM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. W. Laxson 597 W. W. LAXSON, M.D.	VA Center, Boise, Idaho.	7-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 8, 1967	Morris Hill Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-13-67	Myrtle Palmer	J. Richard Reed	E-440

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 17 1967

AUG 3 1967

AUG 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2794
Local Reg. No. 355
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
JUL 13 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 01 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 6 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 01 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 316 West Washington Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARY ELLA	McKEAN	SHAW	July 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Jan. 7, 1871	96				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Chester County, Minnesota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles McKean — BIRTHPLACE: Wahpeton, N. D.
14. MOTHER'S MAIDEN NAME: Frances Ambler — BIRTHPLACE: Chester, Connecticut

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 510-09-0009
17. INFORMANT'S OWN SIGNATURE: W. W. Shaw — ADDRESS: 1119 Warm Springs Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — 2
DUE TO (c): Senility; Diabetes Mellitus — 3

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—	—	—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 11/14, 1949, *to* 7/6, 19 67, *that I last saw the deceased alive on* 7/6, 1967, *and that death occurred at* 10:50 AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 421 MD	Boise	7/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-10-67	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-10-67	Myrtle Palmer	[signature]	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 10 2008

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2705
Local Reg. No. 363
Reg. Dist. No. 370

BIRTH NO.

JUL 13 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits write RURAL): Boise
c. LENGTH OF STAY (in this place): 002
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3800 Kootenai St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Marcella	F. L.	Rubow	July	6,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Oct. 1, 1906	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 81	Same	Hoagland, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gustav H. Hobrook	Unk.	Louise Gerke	Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		567-18-8103	Kent Rubow	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 179.8 Metastatic Carcinoma Breast — INTERVAL BETWEEN ONSET AND DEATH: 12 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March, 1967, *to* July, 1967, *that I last saw the deceased alive on* June 26, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George R Baker	MD	121 E. Idaho Boise	7-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/10/67	Canyon Hill	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-13-67	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 13 1967

FEB 6 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

R. Forney

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 13 1967

State File No. 2796
Local Reg. No. 26
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada — Bureau of Vital Statistics 132
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 32 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchard & Emerald Sts. Boise Convalescent Home, Boise 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 300 No. 16th St.

3. NAME OF DECEASED (Type or Print): a. (First) Lee; b. (Middle); c. (Last) Hope

4. DATE OF DEATH: (Month) 7 (Day) 6 (Year) 67

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: 9-26-02

9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months 7, Days 10 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): painter 27

10b. KIND OF BUSINESS OR INDUSTRY: self

11. BIRTHPLACE (State or foreign country): Rexburg, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: no record — BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 518-12-8544

17. INFORMANT'S OWN SIGNATURE: x Mrs. Emma Hope — ADDRESS: 300 No. 16th St. Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 2001 Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Emphysema — 10 yrs

19a. DATE OF OPERATION: 1/9/67

19b. MAJOR FINDINGS OF OPERATION: Lymphosarcoma

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/21, 1959, *to* 7/6, 1967, *that I last saw the deceased alive on* 7/6, 1967, *and that death occurred at* 10:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard A. Carney, M.D.

23b. ADDRESS: 425 W. Bannock Boise, Idaho

23c. DATE SIGNED: 7/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 7-10-67

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 7-13-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Russell A. Relyea — LICENSE NO.: E-412

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 28 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 2 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2797
Local Reg. No. 376
Reg. Dist. No. 370

Certificate of Death

RECEIVED
JUL 19 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 5709 Fairview

3. NAME OF DECEASED (Type or Print)
a. (First): Okie
b. (Middle): Dobson
c. (Last): Amsdell

4. DATE OF DEATH (Month) (Day) (Year): July 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 6, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Pansy, Penn.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Dobson — BIRTHPLACE: U.S.A.
14. MOTHER'S MAIDEN NAME: Nancy Ellen Dobson — BIRTHPLACE: U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-44-3201
17. INFORMANT'S OWN SIGNATURE: X E. Ruth Barker — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Stroke

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): atherosclerosis
DUE TO (c): Diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/1/63 *19*__, *to* 7/2/67 *19*__, *that I last saw the deceased alive on* 7/6/67 *19*__, *and that death occurred at* 5:55 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 054 Ray Berry M.D.
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 7/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-11-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-17-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Daniel G. Gibson — LICENSE NO. E-[illegible]

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Clohessy

BIRTH NO.

RECEIVED JUL 12 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2798
Local Reg. No. 359
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY 011 Ada 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011 b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 2118 Targee St.

3. NAME OF DECEASED (Type or Print) a. (First) Harold b. (Middle) Edwin c. (Last) Errington

4. DATE OF DEATH (Month) (Day) (Year) 7-7-67

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH 12-27-1898
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR Months 6 Days 10 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) salesman 24
10b. KIND OF BUSINESS OR INDUSTRY - - -
11. BIRTHPLACE (State or foreign country) Pepperell, Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Walter Errington BIRTHPLACE Raleigh, Mass.
14. MOTHER'S MAIDEN NAME Elizabeth Granger BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW I 3
16. SOCIAL SECURITY NO. 004-05-8321
17. INFORMANT'S OWN SIGNATURE Everett W. Newhall ADDRESS Boise, 2118 Targee,

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5271

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor Pulmonale

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic pulmonary emphysema.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/4, 1967, *to* 7/6, 1967, *that I last saw the deceased alive on* 7/6, 1967, *and that death occurred at* 8:45 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE Clohessy 095 (Degree or title) M.D. 1
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED 7/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE 7-11-67
24c. NAME OF CEMETERY OR CREMATORY Demerett Cemetery
24d. LOCATION (City, town, or county) (State) Rumford, Oxford Co., Maine

DATE REC'D BY LOCAL REG. 7-12-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Russell A. Relyea
LICENSE NO. E-412
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2799
Local Reg. No. 374
Reg. Dist. No. 370

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

JUL 19 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: 011 Ada 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township or town): Boise

c. LENGTH OF STAY (If not in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: 140 Canyon

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural---Caldwell

d. STREET ADDRESS (If rural, give location): Route 4

3. NAME OF DECEASED (Type or Print)

a. (First): Earl

b. (Middle): P.

c. (Last): Fithian

4. DATE OF DEATH (Month) (Day) (Year): July 8, 1967.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 30, 1907

9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk 25

10b. KIND OF BUSINESS OR INDUSTRY: Irrigation

11. BIRTHPLACE (State or foreign country): Wolbach, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George E. Fithian — BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Minnie Black — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-07-2146

17. INFORMANT'S OWN SIGNATURE: Helen Fithian — ADDRESS: Rt 4-Caldwell, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Adenocarcinoma of colon with liver & lung metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs —

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct., 1965, *to* July 8, 1967, *that I last saw the deceased alive on* July 8, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Glenn C. Sallny MD 520 — **23b. ADDRESS**: 125 E. Idaho — **23c. DATE SIGNED**: 7/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 11, 1967

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens

24d. LOCATION (City, town, or county) (State): Canyon County, Idaho.

DATE REC'D BY LOCAL REG.: 7-14-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Richard W. Mesenbrink — LICENSE NO.: E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 14 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 29 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2800
Local Reg. No. 105
Reg. Dist. No. 371

RECEIVED JUL 13 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN Boise
c. LENGTH OF STAY (in this place) Bureau of Vital Statistics (township)
d. FULL NAME OF HOSPITAL OR INSTITUTION Boise Valley Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3115 Sycamore

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Marshall	Edwin	Cope	July 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	April 20, 1873	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04		St. Clair County, Michigan	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Austin Cope	Unk	Mary Jane Hillman	Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-18-7083	A. E. Alden	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4200 Arteriosclerotic heart disease. — INTERVAL BETWEEN ONSET AND DEATH: Few yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Senility; deafness; benign prostatic hypertrophy. — Yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-17, 1954, *to* 7-8, 1962, *that I last saw the deceased alive on* 7-2, 1967, *and that death occurred at* 8:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Newcombe 387	MD	512 N. 16 St Boise Idaho	7-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/15/67	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-13-67	Myrtle Palmer	Hazell Waggoner	E-432

FIRM NAME: McBratney-Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2801
Local Reg. No. 361
Reg. Dist. No. 370

BIRTH NO.

JUL 13 1967 2-02 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 011 Boise
d. STREET ADDRESS (If rural, give location): 105 East Idaho Street

3. NAME OF DECEASED (Type or Print)
a. (First): MARGUERITE
b. (Middle): 292 NOLAN
c. (Last): LEMP

4. DATE OF DEATH (Month) (Day) (Year): July 8, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 14, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Roscommon, Michigan
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Nolan — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Mary Roach — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-54-3600
17. INFORMANT'S OWN SIGNATURE: (Miss) Catherine Lemp — ADDRESS: 105 E. Idaho St Boise, Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart disease — ?
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Senility — ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/16, 1960 *to* 7/8, 1967, *that I last saw the deceased alive on* 7/2, 1967, *and that death occurred at* 6:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. Bandrath M.D. 421
23b. ADDRESS: Boise
23c. DATE SIGNED: 7/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-10-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Charles M. Murphy — LICENSE NO.: E-410

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

DUTIES:

JUL 13 1967

MAR 18 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2802
Local Reg. No. 378
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 17 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 41 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1415 Franklin Street

3. NAME OF DECEASED (Type or Print)
a. (First): JENVIER
b. (Middle): MARIE 332
c. (Last): MOUTRAY

4. DATE OF DEATH (Month) (Day) (Year): July 8, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 3, 1884
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Paris, France
12. CITIZEN OF WHAT COUNTRY?: France

13. FATHER'S NAME: De Montuel — BIRTHPLACE: No record
14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 519-07-6903
17. INFORMANT'S OWN SIGNATURE: Faye B. Taggart — ADDRESS: 6500 Robertson Dr. Boise, Idaho

18. CAUSE OF DEATH 332X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Arteriosclerosis and thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 6:45 AM *from the causes and on the date stated above.*

23a. SIGNATURE: O. C. Johnson 261 (Degree or title): M.D.
23b. ADDRESS: Boise Ida
23c. DATE SIGNED: 7-8-'67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 10, '67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-17-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Howell Demaray
LICENSE NO.: E-509
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 25 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED
JUL 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 2803
Local Reg. No. 103
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 2-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
c. LENGTH OF STAY (in this place): 6 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Sunset Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 715 North 13th Street

3. NAME OF DECEASED (Type or Print)
a. (First): BELLE
b. (Middle): JENNIE 235
c. (Last): FELTNER

4. DATE OF DEATH (Month) (Day) (Year): July 8, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov. 14, 1891
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Greeley, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John William Priest — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Cora Emma Ranzenberger — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-07-8150
17. INFORMANT'S OWN SIGNATURE: Paul E. Feltner — ADDRESS: 1108 N. 9th Boise, Idaho

18. CAUSE OF DEATH 4500
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Kremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mo

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Generalized Arteriosclerosis — 2 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1963 *to* July 8, 1967, *that I last saw the deceased alive on* July 8, 1967, *and that death occurred at* 11:45 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 088 (on S)
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 7/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-11-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-509

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

DUTIES:

JUL 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 17 1993

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2804
Local Reg. No. 358
Reg. Dist. No. 370

RECEIVED JUL 12 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1525 Malad

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Blanche	R.	Quinliven	July 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Married 3	March 1, 1929	38				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Drug Store 21	Cosmotician	Casper, Wyo.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
[redacted]	Evansville, Ind.	Dorothy Scofield	Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
			Mrs. Catherine Andree	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Third Degree Burns 70% of Body Surface — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Terminal Ruptures of Esophagus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Autopsy *to* July, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Miles F. Thomas 529 MD		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-12-67	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-12-67	Myrtle Palmer	Daniel G. Gibson	E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

JUL 25 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 15 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 22 2008

OCT 22 2008

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2805
Local Reg. No. 362
Reg. Dist. No. 370

RECEIVED
JUL 13 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 425 West Jefferson St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 011 Boise
d. STREET ADDRESS (If rural, give location): Apt. #29 425 West Jefferson Street

3. NAME OF DECEASED (Type or Print)
a. (First): JAY
b. (Middle): 000 PARKIN
c. (Last): DICKSON

4. DATE OF DEATH (Month) (Day) (Year): July 9, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: May 27, 1940
9. AGE (In years last birthday): 27 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ticket Clerk - 10
10b. KIND OF BUSINESS OR INDUSTRY: Greyhound Bus Co.
11. BIRTHPLACE (State or foreign country): Woods Cross, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME / BIRTHPLACE: Wayne Dickson, Idaho Falls, Idaho
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Eliza Parkin, Woods Cross, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 520-38-1087
17. INFORMANT'S OWN SIGNATURE: Wayne B Dickson — ADDRESS: Green River Wyoming

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Septicemia with 0571

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Waterhouse-Friderichsen
DUE TO (c): syndrome

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Autopsy, *to* only, *19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Miles Thomas MD 529
23b. ADDRESS: 506 N 5th Boise
23c. DATE SIGNED: 12 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 7-12-67
24c. NAME OF CEMETERY OR CREMATORY: Resthaven Memorial Gardens-Rock Springs, Wyoming
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: 7-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Fred E. Walker
LICENSE NO.: E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 17 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 21 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 31 1967

OCT 05 1995

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2806
Local Reg. No. 371
Reg. Dist. No. 370

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 — JUL 17 1967 — 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idhao 011
d. STREET ADDRESS (If rural, give location): 2110 North 15th

3. NAME OF DECEASED (Type or Print): a. (First) EDITH — b. (Middle) DELL — c. (Last) WILSON

4. DATE OF DEATH: (Month) July (Day) 10, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: August 12, 1904

9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School teacher 12

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (State or foreign country): Marble, Arkansas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Steve Gilbert Hudson — BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Sarah Ellen Spencer — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-26-9825

17. INFORMANT'S OWN SIGNATURE: Hugh Wilson — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardiovascular Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Renal Insufficiency

423X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 13, 1967, *to* July 10, 1967, *that I last saw the deceased alive on* July 9, 1967, *and that death occurred at* A. m., *from the causes and on the date stated above.*

23a. SIGNATURE C. O. Nelson 261 (Degree or title) — **23b. ADDRESS** — **23c. DATE SIGNED**

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: July 12, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Dry Creek Cemetery — **24d. LOCATION** (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 7-14-67 — REGISTRAR'S SIGNATURE: Myrtle Palmer — **25. EMBALMER**: Russell C. Relyea — LICENSE NO.: E-412

FIRM NAME: Relyea Mortuary, Boise, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2807
Local Reg. No. 107
Reg. Dist. No. 371

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

JUL 20 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 3 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural 010
d. STREET ADDRESS (If rural, give location): Rt. 3

3. NAME OF DECEASED (Type or Print)
a. (First): Earl
b. (Middle): H.
c. (Last): Johnson

4. DATE OF DEATH (Month) (Day) (Year): July 11, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 16, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04 Retired
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baraboo, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis Johnson — BIRTHPLACE: unk
14. MOTHER'S MAIDEN NAME: unk. — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-44-8386
17. INFORMANT'S OWN SIGNATURE: Kenneth V. Johnson — ADDRESS: Orofino, Ida

18. CAUSE OF DEATH 334X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): cerebral arteriosclerosis — 10 yrs
DUE TO (c): Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
1) ASHD
2) Chronic deforming rheumatoid arthritis

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1965, *to* July, 1967, *that I last saw the deceased alive on* 10 July 67, 19__, *and that death occurred at* 3:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lee Pulley 624 Wm
23b. ADDRESS: 925 E 1st Meridian Ida
23c. DATE SIGNED: 13 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-15-67
24c. NAME OF CEMETERY OR CREMATORY: Mt. View Mausoleum
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-19-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jerread
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2808
Local Reg. No. 366
Reg. Dist. No. 370

BIRTH NO. RECEIVED

1. PLACE OF DEATH
a. COUNTY 011 Ada JUL 13 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) Bureau of Vital Statistics 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. St. Lukes 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 1302 Hays Way

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) Bowden
c. (Last) White

4. DATE OF DEATH (Month) (Day) (Year) July 11, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Oct. 24, 1909

9. AGE (In years last birthday) 57
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Prop. 22

10b. KIND OF BUSINESS OR INDUSTRY Appliance Repair

11. BIRTHPLACE (State or foreign country) Camas, Utah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Ray White
BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Asenath L. Bowden
BIRTHPLACE Golden, Colo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-07-9070

17. INFORMANT'S OWN SIGNATURE X Mrs. John B. White
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — *19*____, *to* —, *19*____, *that I last saw the deceased alive on* _____, *19*____, *and that death occurred at* 2:15 PM., *from the causes and on the date stated above.*

23a. SIGNATURE C C Johnson 26 (Degree or title) MD

23b. ADDRESS Boise Idaho

23c. DATE SIGNED 7-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 14, 1967

24c. NAME OF CEMETERY OR CREMATORY Dry Creek

24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. 7-13-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Earl Waggoner

LICENSE NO. E 422

FIRM NAME McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 8 1991

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2809
Local Reg. No. 106
Reg. Dist. No. 371

BIRTH NO.

RECEIVED JUL 17 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN: Boise, Idaho.
c. LENGTH OF STAY (in this place): 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon. 38
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baker
d. STREET ADDRESS (If rural, give location): 2050 Plum Street.

3. NAME OF DECEASED (Type or Print): a. (First) Harry b. (Middle) Charles c. (Last) DUCKWORTH.

4. DATE OF DEATH: (Month) 7 (Day) 11 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: 4-17-94

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired. 29

10b. KIND OF BUSINESS OR INDUSTRY: Unknown.

11. BIRTHPLACE (State or foreign country): Illinois.

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Charles Duckworth. BIRTHPLACE: Unknown.

14. MOTHER'S MAIDEN NAME: Barbara Lentz. BIRTHPLACE: Illinois.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 13

16. SOCIAL SECURITY NO.: 543 26 2786

17. INFORMANT'S OWN SIGNATURE: R. Moore ADDRESS: VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7440

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bulbar Palsy — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Myesthenia gravis — 4 wks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-8, 1967, to 7-11, 19 67 that I last saw the decedent alive on ... and that death occurred at 6 PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): GLENN Q VOYLES, M.D.

23b. ADDRESS: VA Center, Boise, Idaho.

23c. DATE SIGNED: 7-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3

24b. DATE: July 12, 1967

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State): Baker, Oregon

DATE REC'D BY LOCAL REG.: 7-13-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: J. Richard Reed

LICENSE NO.: E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUL 19 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2810
Local Reg. No. 380
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 011 Boise
d. STREET ADDRESS (If rural, give location) 422 South Tenth

3. NAME OF DECEASED (Type or Print)
a. (First) SADIE
b. (Middle) IRENE
c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year) July 11, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH May 7, 1888
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Sac City, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Grant Alexander — BIRTHPLACE Sac City, Iowa
14. MOTHER'S MAIDEN NAME Emma Belvail — BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. 518-09-4621
17. INFORMANT'S OWN SIGNATURE 422 S.10th ADDRESS Zola I. Roark Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 241X Pulmonary Obstructive Disease — 6 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Asthma — 6 yr
DUE TO (c) Emphysema — 2 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1966 *to* July 10, 1967, *that I last saw the deceased alive on* July 11, 1967 *and that death occurred at* 2:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 088 (Degree or title) M.D.
23b. ADDRESS — Boise Idaho
23c. DATE SIGNED 7/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 15'67
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 7-19-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUL 19 1967

Certificate of Death

STATE OF IDAHO

State File No. 2811
Local Reg. No. 381
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH — Bureau of Vital Statistics
a. COUNTY: Ada 011 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1104 Catalina Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ROBERT	A.	SCHUPPENIES	July	11,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Feb. 11, 1905	62	5	0		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
State Saftey Supervisor	State Highway Dept.	Panama, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
August Carl Schuppenies 08	Sprakton, East Prussia	Elizabeth Sprenger	Brilon, Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No 0	519-05-5503	Mrs Robert A. Schuppenies	1104 Catalina Rd. Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of stomach, — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) causing obstruction of esophagus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hiatal hernia — 6 mos

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/14/67	Carcinoma of stomach with metastases	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 2/7 *19*67, *to* 7/11, 1967, *that I last saw the deceased alive on* 7/10, 1967, *and that death occurred at* 4:20 A *m., from the causes and on the date stated above.* 7/11/67

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert A Smith MD		312 W Idaho Boise, Idaho.	7/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7-11-1967	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-67	Myrtle Palmer	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 25 1967

AUG 1 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

Amended August 17, 1967

Certificate of Death

STATE OF IDAHO

State File No. 2812
Local Reg. No. 372
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 19 years 1-19
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1706 Jessie Street

3. NAME OF DECEASED (Type or Print): a. (First) Deryl; b. (Middle); c. (Last) Thornton

4. DATE OF DEATH: (Month) July (Day) 12, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 13, 1913

9. AGE (In years last birthday): 53
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Malad, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ephriam Thornton
BIRTHPLACE: Malad, Idaho

14. MOTHER'S MAIDEN NAME: Agnes Jeanette Hickman
BIRTHPLACE: LaBelle, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 529-20-7704

17. INFORMANT'S OWN SIGNATURE: Ruth S. Thornton
ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July 7, 1967, *to* July 12, 1967, *that I last saw the deceased alive on* July 12, 1967, *and that death occurred at* 11:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. C. Johnson, M.D. 261
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 7-14-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Fred J. Nelson
LICENSE NO.: E-504

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Relyea Mortuary, Boise, Idaho

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

344 4441

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED AUG 16 1967 Bureau of Vital Statistics

State of Idaho
County of Ada } ss.

Certificate No.

Date Filed July 14, 1967

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death) for Deryl Thornton (Name on Original Certificate) who died (Was Born or Died) on July 12, 1967 (Date of Event) in (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by family records (Bible Record, Insurance Policy, Etc.) prepared on July 29, 1967 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Birthdate	July 5, 1967, age 54	July 13, 1913, age 53
Mother's maiden name	Nettie Hickman	Agnes Jeanette Hickman

Subscribed and sworn to before me this 29th day of July, 1967

Phyllis B. Grant
Notary Public, residing at Boise Idaho
My commission expires Mar. 1968
(Seal)

Signed Ruth S. Thornton
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Ada } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 29th day of July, 1967

Phyllis B. Grant
Notary Public, residing at Boise Idaho
My commission expires Mar. 1968
(Seal)

Signed Conway Grant
(Signature of Any Credible Person)

318 No Latah, Boise, Idaho
(Street Address, City, State)

FORM DH 60-155 3 cps 1 VA 2 pd

NOTARY
PUBLIC
STATE OF IDAHO

NOTARY
PUBLIC
STATE OF IDAHO

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 372
Reg. Dist. No. 370

RECEIVED
JUL 17 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 19 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1706 Jessie Street

3. NAME OF DECEASED (Type or Print): a. (First) DERYL b. (Middle) c. (Last) THORNTON

4. DATE OF DEATH: (Month) July (Day) 12, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 5, 1967

9. AGE (In years last birthday): 54
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Malad, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ephriam Thornton
BIRTHPLACE: Malad, Idaho

14. MOTHER'S MAIDEN NAME: Nettie Hickman
BIRTHPLACE: LaBelle, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 529-20-7704

17. INFORMANT'S OWN SIGNATURE: X Ruth A. Thornton
ADDRESS: Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis — 5 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 7, 1967, to July 12, 1967, *that I last saw the deceased alive on* July 12, 1967, *and that death occurred at* 11 45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: C C Johnson (Degree or title) M D
23b. ADDRESS: Boise Ida
23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 7-14-67
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: C C Johnson
LICENSE NO.: E-504
FIRM NAME: Nelson Mortuary, Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 17 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 4 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2813
Local Reg. No. 390
Reg. Dist. No. 370

Certificate of Death

RECEIVED JUL 25 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 1-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 3 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 011 Boise
d. STREET ADDRESS (If rural, give location) AVe. N. and Reserve Street

3. NAME OF DECEASED (Type or Print)
a. (First) Apolonia
b. (Middle) ------
c. (Last) Matusik

4. DATE OF DEATH (Month) (Day) (Year) July 12, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 9, 1885
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Czechoslovakia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jakup Preik — BIRTHPLACE Czechoslovakia
14. MOTHER'S MAIDEN NAME Resina Myke — BIRTHPLACE Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Pete Matusik — ADDRESS Boise, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemiplegia, Rt. — INTERVAL BETWEEN ONSET AND DEATH 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1960, *to* July 12, 1967, *that I last saw the deceased alive on* July 11, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE George R Baker, MD 019 (Degree or title)
23b. ADDRESS 121 E. Idaho, Boise
23c. DATE SIGNED 7/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-15-67
24c. NAME OF CEMETERY OR CREMATORY Cloverdale
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 7-20-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Eldon T. Pearson — LICENSE NO. E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: GibsonFuneral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 2814
Local Reg. No. 392
Reg. Dist. No. 370

BIRTH NO.

RECEIVED STATE OF IDAHO

JUL 25 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 142
d. STREET ADDRESS (If rural, give location): 115 Juniper St.

3. NAME OF DECEASED (Type or Print)
a. (First): Juanita
b. (Middle): Tiller
c. (Last): Henkel

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 26, 1920
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Clerk 25
10b. KIND OF BUSINESS OR INDUSTRY: drug store
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William J. Tiller — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Evva Scism — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-05-7143
17. INFORMANT'S OWN SIGNATURE: Alex J Henkel — ADDRESS: Nampa

18. CAUSE OF DEATH 8300
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Multiple traumatic injuries:1, Extensive pelvic fractures;2,Compound comminuted fracturesright tibia with extensive tissue loss and fracture left femur.3, Ruptured uterus and tear left ovarian artery.4,Perforated ilium.5,Extensive tear if mesentery if sigmoid colon; 6*

ANTECEDENT CAUSES — DUE TO (b): 7/3/67 -
DUE TO (c): 7/12/67

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 7/3/67
19b. MAJOR FINDINGS OF OPERATION: Ruptured uterus, tear of mesentery of sigmoid colon, tear left ovarian artery, amp-**
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Cascade Fishing Dock
21c. (CITY, TOWN, OR TOWNSHIP): 13 Boise — (COUNTY): 011 Ada — (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7/3/67 25 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Struck by pickup truck

22. *I hereby certify that I attended the deceased from* July 3, 1967, *to* July 12, 1967, *that I last saw the deceased alive on* July 12, 1967, *and that death occurred at* 2:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE: James H Hawley 216 (Degree or title) MD
23b. ADDRESS: 850 S. Latah, Boise, Ida.
23c. DATE SIGNED: 7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county): Canyon County — (State): Idaho

DATE REC'D BY LOCAL REG.: 7-24-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Tony S. Kroeck — LICENSE NO.: E-447

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALSIP FUNERAL CHAPEL

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to obtain the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

JAMES H. HAWLEY, M. D.
850 South Latah
BOISE, IDAHO

Certificate of Death (continued)
Re: Juanita Henkel

*6., Profound shock, secondary to above.
7., Bacteremia, secondary to infected stump.

**amputation, right leg, at knee.

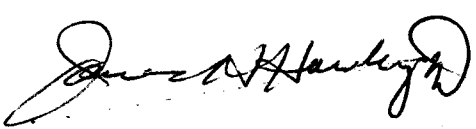

RECEIVED
JUL 25 1967
Bureau of Vital Statistics

JUL 25 1967
AUG 21 1967
AUG 22 1967
OCT 31 1968

Certificate of Death

STATE OF IDAHO

State File No. 2815
Local Reg. No. 389
Reg. Dist. No. 370

RECEIVED JUL 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 2-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 7 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1718 North 12th

3. NAME OF DECEASED (Type or Print)
a. (First): GLADYS
b. (Middle): GERTRUDE
c. (Last): LAWRENCE

4. DATE OF DEATH: (Month) July (Day) 12, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: July 7, 1889

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Homemaker

11. BIRTHPLACE (State or foreign country): Tell City, Indiana

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John McDaniel
BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Mary Doughty
BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-60-4029T

17. INFORMANT'S OWN SIGNATURE: Charles R Lawrence
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/17/66, 19__, *to* 7/12/67 19__, *that I last saw the deceased alive on* 7/11/67, 19__, *and that death occurred at* 1:55 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 054 (Degree or title) McD

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 7/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: July 14, 1967

24c. NAME OF CEMETERY OR CREMATORY: Pleasant Grove Cemetery

24d. LOCATION (City, town, or county) (State): Advance Missouri

DATE REC'D BY LOCAL REG.: 7-20-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Russell A. Relyea
LICENSE NO.: E-412
FIRM NAME: Relyea Mortuary Boise, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2816
Local Reg. No. 382
Reg. Dist. No. 370

RECEIVED JUL 19 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) Dk. Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hosptial 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 417 Union

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lauretta	Eckersell	Thomas	July 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	December 6, 1887	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaker	Rexburg, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Eckersell	Wellsville, Utah	Diana Taylor	Smithfield, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Raymond L Gray	Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Acute Coronary occlusion 4201	½ hour
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	D.D.A. - St Lukes Hosp.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___ *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
216 Jean H Hawley MD		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 17, 1967	Rexburg Cemetery	Rexburg, Madison, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-67	Myrtle Palmer	Fred J Nelson	E-504

FIRM NAME: Relyea Mortuary Boise, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2817
Local Reg. No. 397
Reg. Dist. No. 270

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 6 weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 2708 Nez Perce

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

3. NAME OF DECEASED (Type or Print)
a. (First) Pearl
b. (Middle)
c. (Last) Wolf

4. DATE OF DEATH (Month) (Day) (Year) July 13, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 28, 1899
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Homemaker
11. BIRTHPLACE (State or foreign country): Nacoma, Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Milton Jennings — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs. Glenna Way — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Kidney failure — INTERVAL BETWEEN ONSET AND DEATH: ? 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Left ureteral Stone, Left pyelonephritis

593X

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 19 58, *to* July 13, 19 67, *that I last saw the deceased alive on* July 13, 19 67, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: M J Lepere 259 (Degree or title) MD
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 7/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 7-25-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Russell C. Kelyea — LICENSE NO. E-412
FIRM NAME: Kelyea Mortuary, Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 3 0 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2818
Local Reg. No. 379
Reg. Dist. No. 370

RECEIVED JUL 17 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada — 1-07
b. CITY OR TOWN: Boise
(If outside corporate limits, write RURAL and give township)
LENGTH OF STAY (in this place): 7 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1612 North 16th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1612 North 16th Street

3. NAME OF DECEASED (Type or Print)
a. (First): JOSEPH
b. (Middle): 000
c. (Last): ALKANA

4. DATE OF DEATH (Month) (Day) (Year): July 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 13, 1919	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer 21	Engineering	Seattle, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Sam Alkana	Island of Rhodes	Emily Hasson	Island of Rhodes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	531-14-4884	Billie J. Alkana	1612 N. 16th St. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Myocardial Failure	1-2 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Rheumatic Valvular	?
DUE TO (c)	Heart Disease	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	—	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—	—	—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
— m.		

22. *I hereby certify that I attended the deceased from* 7/6, *19*48, *to* 7/13, *19*67, *that I last saw the deceased alive on* 7/15, *19*67, *and that death occurred at* 3:20 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 421 MP	Boise	7/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-15-67	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-17-67	Myrtle Palmer	Lowell Summers	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 25 1967 Bureau of Vital Statistics

State File No. 2819
Local Reg. No. 397
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 4-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): few hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn. Home 010
d. STREET ADDRESS (If rural, give location): 1215 Elm Street

3. NAME OF DECEASED (Type or Print)
a. (First): Kevin
b. (Middle): Dean
c. (Last): Swindell

4. DATE OF DEATH (Month) (Day) (Year): July 14, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Nevered Married
8. DATE OF BIRTH: July 12, 1965
9. AGE (In years last birthday): 2 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Mtn Home, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Irvin Swindell — BIRTHPLACE: Oxford, Nebraska
14. MOTHER'S MAIDEN NAME: Berniece, House — BIRTHPLACE: West Plains, Miss.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No 0
16. SOCIAL SECURITY NO.: ———
17. INFORMANT'S OWN SIGNATURE: + Irvin A. Swindell — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

522X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Edema

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Etiology undetermined

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 14, 1967, *to* July 14, 1967, *that I last saw the deceased alive on* July 14, 1967, *and that death occurred at* 8:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Al H. Kuyhendall 704 (Degree or title)
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 17, 1967
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 7-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Fred J. Nelson — LICENSE NO. E-504

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Relyea Mortuary
Boise, Idaho

AUG 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUN 16 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2820
Local Reg. No. 3920
Reg. Dist. No. 370

RECEIVED STATE OF IDAHO

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 011 Ada — JUL 20 1967 — 1-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY IN THIS PLACE 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2114 North 16th 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 2114 North 16th

3. NAME OF DECEASED (Type or Print)
a. (First) CARL
b. (Middle) EDWIN
c. (Last) BURNETT

4. DATE OF DEATH (Month) (Day) (Year) July 14, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH Nov. 19, 1915

9. AGE (In years last birthday) 51
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) television technician 21

10b. KIND OF BUSINESS OR INDUSTRY television

11. BIRTHPLACE (State or foreign country) Seymour, Texas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Taylor Burnett — BIRTHPLACE Kentucky

14. MOTHER'S MAIDEN NAME Martha E. Carroll — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) W. W. II 4

16. SOCIAL SECURITY NO. 542-05-4385

17. INFORMANT'S OWN SIGNATURE 1927 Cecelia Cir. ADDRESS John T. Burnett Salt Lake City

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4-20-67

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Recenly in Vets; Hospital for Cardiac Treatments. — weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not to See to Alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE 583 Ed. Parks 4 (Degree or title) Coroner

23b. ADDRESS 3720 Meadow Drive, Boise,

23c. DATE SIGNED 7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE July 18, 1967

24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 7-20-67

REGISTRAR'S SIGNATURE Myrtle Palmer by [illegible]

25. EMBALMER J. Willard Reed

LICENSE NO. E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
PH-630(2)

JUL 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2821
Local Reg. No. 273
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
JUL 27 1967

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. St. Alphonsus Hos

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale 370
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print): a. (First) E. b. (Middle) 000 c. (Last) LeRoy Fessner

4. DATE OF DEATH: (Month) July (Day) 14, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	April 13, 1947	20	3	1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Self.
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ernest J. Fessner — BIRTHPLACE: BlackHawk, Colo.
14. MOTHER'S MAIDEN NAME: Beatrice Erwin — BIRTHPLACE: Leadore, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-48-7437
17. INFORMANT'S OWN SIGNATURE: X Leroy J. Fessner — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Inhaled Vomit. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Blood Alcohol Test, 0.90.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Had been in two fights, and swallowed Mucus and blood. — 20 Mins;

9369

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 1155P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 583 C.D. Sims Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Wilder Cemetery
24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: 7-24-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Homedale's Flahiff Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 1 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 10 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-106 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2822
Local Reg. No. 789
Reg. Dist. No. 371

BIRTH NO.

JUL 27 1967

Bureau of Vital Statistics

1-29

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 29 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Nursing Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1920 Palouse St.

3. NAME OF DECEASED (Type or Print): a. (First) Grace b. (Middle) M. c. (Last) Hoffman

4. DATE OF DEATH: (Month) (Day) (Year) July 14, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: June 12, 1878

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Blair, Nebr.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W. Mayle
BIRTHPLACE: Penn.

14. MOTHER'S MAIDEN NAME: Martha J. McCleod
BIRTHPLACE: Ky.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-18-7073

17. INFORMANT'S OWN SIGNATURE: Roger K. Hoffman
ADDRESS: 1920 Palouse Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis Gen — 1
DUE TO (c) Senility —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mental Deterioration — 18 mo.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-22-, 19[illegible], *to* 7-14-, 1967, *that I last saw the deceased alive on* 7-14-, 1967, *and that death occurred at* 6 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl B. Smithson MD

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 18, 1967

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: 7-24-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Merville D. Davis

LICENSE NO.: E-399

FIRM NAME: Beckham-Dakan Chapel Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory [illegible], indicating only symptoms of disease or conditions resulting from disease, will not be held [illegible] for issuing a burial or removal permit; and any certificate containing only such terms [illegible]tate registrar as indefinite and unsatisfactory, shall be returned to the [illegible] and definition. The international classification of the causes of [illegible]icians in stating the cause of death in the medical certificate. [illegible]sult of either disease or violence, shall be carefully defined; and [illegible]shall be stated, and whether (probably) accidental, suicidal, or homi[illegible]

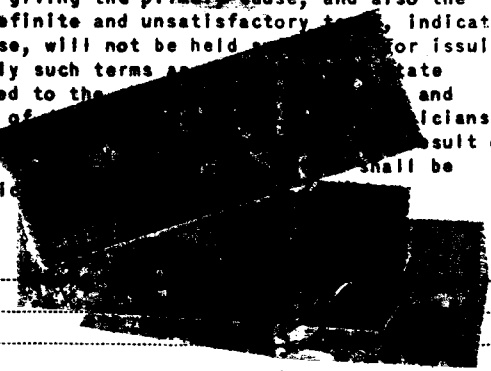

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2823
Local Reg. No. 384
Reg. Dist. No. 370

RECEIVED JUL 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada — 5-15
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise — LENGTH OF STAY (in this place) 15 Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise — 011
d. STREET ADDRESS (If rural, give location) 903 Richmond

3. NAME OF DECEASED (Type or Print) — a. (First) Arthur — b. (Middle) Lewis 003 — c. (Last) LaSalle

4. DATE OF DEATH (Month) (Day) (Year) July 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Dec. 5, 1880	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Western Union 09
10b. KIND OF BUSINESS OR INDUSTRY Western Union
11. BIRTHPLACE (State or foreign country) Helena, Montana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME LaSalle — BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Victoria Herbert — BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 516-07-0617
17. INFORMANT'S OWN SIGNATURE Mrs. C. LaSalle — ADDRESS Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH 5 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — generalized — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

33 X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* 15 July, 19 67, *that I last saw the deceased alive on* 15 July, 19 67, *and that death occurred at* 9:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 510 — 23b. ADDRESS Boise, Idaho — 23c. DATE SIGNED 17 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE 7-19-67 — 24c. NAME OF CEMETERY OR CREMATORY Morris Hill — 24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 7-19-67 — REGISTRAR'S SIGNATURE Myrtle Palmer — 25. EMBALMER Daniel G. Gibson — LICENSE NO. E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 17 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2824
Local Reg. No. 475
Reg. Dist. No. 370

RECEIVED AUG - 4 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 4 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian, Idaho 010
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Herbert
b. (Middle)
c. (Last) Pilkington

4. DATE OF DEATH (Month) (Day) (Year) July 15, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Feb. 10, 1889
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) REtired 04
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Marshfield, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Pilkington — BIRTHPLACE Wright Co. Miss.
14. MOTHER'S MAIDEN NAME Rebecca Yates — BIRTHPLACE North Caroline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-10-9685
17. INFORMANT'S OWN SIGNATURE Glenn E. Phillips — ADDRESS Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible] accident

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) [illegible]
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/19/67, 19__, *to* 7/15/67, 19__, *that I last saw the deceased alive on* 7/15/67, 19__, *and that death occurred at* 11:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE [illegible] 054 (Degree or title) [illegible]
23b. ADDRESS [illegible] Idaho
23c. DATE SIGNED 8/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 18, 1967
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Ada, Idaho

DATE REC'D BY LOCAL REG. 8-3-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Fred J. Nelson — LICENSE NO. E-504

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Relyea Mortuary
Boise, Idaho

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2825
Local Reg. No. 374
Reg. Dist. No. 370

RECEIVED JUL 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1303 N. Manville

3. NAME OF DECEASED (Type or Print)
a. (First): CLYDE
b. (Middle): K.
c. (Last): WYLIE

4. DATE OF DEATH (Month) (Day) (Year): July 15, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widower 2
8. DATE OF BIRTH: Sept. 4, 1872
9. AGE (In years last birthday): 94 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mail Carrier 08
10b. KIND OF BUSINESS OR INDUSTRY: U.S.Government
11. BIRTHPLACE (State or foreign country): Andrew, Iowa
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Edmund B. Wylie — BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Elizabeth McConnel — BIRTHPLACE: Penn.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Yes
17. INFORMANT'S OWN SIGNATURE: + Clifford E. Wylie — ADDRESS: Boise Ida

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchy insufficiency
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Heart block + Anemia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/15, 1965, *to* 7-15, 1967, *that I last saw the deceased alive on* 7/14, 1967, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 528 (Degree or title)
23b. ADDRESS: 305 Fort St. Boise 36
23c. DATE SIGNED: 7/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/18/67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 7-24-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters [signature] LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

SEP 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ~~ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2826
Local Reg. No. 395
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 25 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 328 S. Phillippi

3. NAME OF DECEASED (Type or Print): a. (First) GRACE b. (Middle) C. c. (Last) DIXON

4. DATE OF DEATH: (Month) (Day) (Year) July 16, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 14, 1900

9. AGE (In years last birthday): 66
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Havanna, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thadeous C. Williams
BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Lillie May Robison
BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 566-32-7166

17. INFORMANT'S OWN SIGNATURE: Mrs Wilfred E. Howard
ADDRESS: 328 So. Phillippi

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1600

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Nasal Epithelioma
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 20, 1967, *to* July 16, 1967, *that I last saw the deceased alive on* July 16, 1967, *and that death occurred at* A m., *from the causes and on the date stated above.*

23a. SIGNATURE: C C Thurson (Degree or title) 261 MD 1

23b. ADDRESS: Boise Ida

23c. DATE SIGNED: 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7/18/67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-24-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: G. W. Waters

LICENSE NO.: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2827
Local Reg. No. 111
Reg. Dist. No. 371

RECEIVED JUL 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1½ Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State Penitentiary

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 1-02
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 090
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): G. 178
c. (Last): CLYDE

4. DATE OF DEATH: (Month) July (Day) 16, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Sept. 23, 1901

9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Chippewa Falls, Wisconsin

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Clyde
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Jennie Gregg
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: ---

17. INFORMANT'S OWN SIGNATURE: J. Richard Reed
ADDRESS: From Penitentiary Records Bann

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1992

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Was operated on in Hospital recently, found complete

DUE TO (c): cancer in body, No cure.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 Hrs / Months.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Did Not See to Alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 615 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: 583 O. Paris (Degree or title): Coroner

23b. ADDRESS: 3720 Meadow Drive, Boise,

23c. DATE SIGNED: 7-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: July 26, 1967

24c. NAME OF CEMETERY OR CREMATORY: ISP Cemetery

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 7-26-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Fred E. Walker

LICENSE NO.: E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

William Forney
425 W. Bannock

Certificate of Death

BIRTH NO. 343645 RECEIVED STATE OF IDAHO

State File No. 2828
Local Reg. No. 2728
Reg. Dist. No. 370

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 JUL 19 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Idaho City Stage

3. NAME OF DECEASED (Type or Print): a. (First) Frances b. (Middle) ------- c. (Last) McTaggart

4. DATE OF DEATH: (Month) (Day) (Year) July 16, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 3, 1923

9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Eccles, West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Switzerland

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: 236-18-3625

17. INFORMANT'S OWN SIGNATURE: James McTaggart — ADDRESS: Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) 4201

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* 5-24, 1967, *to* 7-19, 1967, *that I last saw the deceased alive on* 7-13, 1967, *and that death occurred at* 6:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: W.D. Forney 173 (Degree or title) MD

23b. ADDRESS: 425 Bannock Boise

23c. DATE SIGNED: 7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 7-17-67

24c. NAME OF CEMETERY OR CREMATORY: Beckley Cemetery

24d. LOCATION (City, town, or county) (State): Beckley-West Virginia

DATE REC'D BY LOCAL REG.: 7-17-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: -

DEC 6 1967

MAR 12 1968

SEP 7 1983

FEB - 6 1986

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2829
Local Reg. No. 396
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JUL 27 1967 Bureau of Vital Statistics STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 4-12
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 12 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 600 Beacon Street

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) A c. (Last) Monprode

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 7, 1892

9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman 06

10b. KIND OF BUSINESS OR INDUSTRY: Morrison-Knudsen

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Anton Monprode — BIRTHPLACE: Jersey City NJ

14. MOTHER'S MAIDEN NAME: Ida May Grove — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 166-05-3991

17. INFORMANT'S SIGNATURE: Robert A Monprode — ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1637 Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 4 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease — 2 yrs ago

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr 21, 1967, *to* July 17, 1967, *that I last saw the deceased alive on* July 13, 1967, *and that death occurred at* 12:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. R. Blackburn 046 (Degree or title) MD

23b. ADDRESS: 800 Fa Cassia Way Boise

23c. DATE SIGNED: 20 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: 7/21/67

24c. NAME OF CEMETERY OR CREMATORY: Mountain View Crematory

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-24-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature]

LICENSE NO.: E-461

MOUNTAIN VIEW FUNERAL HOME, BOISE

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 2 6 1973

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2830
Local Reg. No. 399
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Star 010
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): M.
c. (Last): Lipps

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 24, 1888
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Clarksburg, W. Virginia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lipps — BIRTHPLACE: unk
14. MOTHER'S MAIDEN NAME: unk — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 555-09-9886
17. INFORMANT'S OWN SIGNATURE: Mrs Douglas Freeborg — ADDRESS: Meridian

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Reticulum Cell Sarcoma of the Sigmoid Colon — INTERVAL BETWEEN ONSET AND DEATH: March 1967

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Aortic Aneurysm due to Arteriosclerosis — March 1967

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* March, 1967, *to* 7/17, 1967, *that I last saw the deceased alive on* 7/17, 1967 *and that death occurred at* 11:55 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Everett N Jones 267 (Degree or title)
23b. ADDRESS: 205 N 10th Boise Ida
23c. DATE SIGNED: 7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-20-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 7-26-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jerread — LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2831
Local Reg. No. 385
Reg. Dist. No. 370

RECEIVED JUL 20 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 210
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 10 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 1020 Fort Street

3. NAME OF DECEASED (Type or Print)
a. (First) MARY
b. (Middle) LASH 292
c. (Last) POPE

4. DATE OF DEATH (Month) (Day) (Year) July 17, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Sept. 3, 1882
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Allyn J. Lash — BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Jean Capehart — BIRTHPLACE Bridgeport, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. 519-36-1041D
17. INFORMANT'S OWN SIGNATURE Agnes M. Williams — ADDRESS 1513 Grant Ave Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Corcinoma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Corcinoma of Breast
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Coronary + Cerebral Arteriosclerosis

170X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1963, *to* July 17, 1967, *that I last saw the deceased alive on* July 16, 1967, *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE C C Johnson 261 (Degree or title) MD
23b. ADDRESS Boise Ida
23c. DATE SIGNED 7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 20, '67
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 7-20-67
REGISTRAR'S SIGNATURE Myrtle Palmer by Helen Olson
25. EMBALMER Fred E. Walker
LICENSE NO. E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form OH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 30 1967

JAN 18 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2832
Local Reg. No. 388
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 Ada — JUL 20 1967 — 0-00
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (In this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — 011
d. STREET ADDRESS (If rural, give location): 2309 Regan

3. NAME OF DECEASED (Type or Print): a. (First) Kenneth — b. (Middle) Dale — c. (Last) Stevenson

4. DATE OF DEATH: (Month) (Day) (Year): July 17, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 4, 1920

9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24

10b. KIND OF BUSINESS OR INDUSTRY: National Ramp.

11. BIRTHPLACE (State or foreign country): Co. Wilder, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Bert Stevenson — BIRTHPLACE: Ill.

14. MOTHER'S MAIDEN NAME: Lizzie Brown — BIRTHPLACE: Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 519-12-1806

17. INFORMANT'S OWN SIGNATURE: Josephine Stevenson — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Has had a Cardiac Condition. — Recent

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 2 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: 583 E. O. Stark — (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise,
23c. DATE SIGNED: 7-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-20-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021 Helen Gibson

JUL 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 01 1998

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2833
Local Reg. No. 108
Reg. Dist. No. 371

RECEIVED JUL 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandy Point 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2716 North 31

3. NAME OF DECEASED (Type or Print): a. (First) Paul b. (Middle) Franklin c. (Last) Parent

4. DATE OF DEATH: (Month) (Day) (Year): July 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Oct. 11, 1962
9. AGE (In years last birthday): 4 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02
10b. KIND OF BUSINESS OR INDUSTRY: Child
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Gary Parent — BIRTHPLACE: East Grand Forks
14. MOTHER'S MAIDEN NAME: Patricia Johnson — BIRTHPLACE: Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: No.
17. INFORMANT'S OWN SIGNATURE: Mrs Gary Parent — ADDRESS: Boise

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by Drowning. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
None Known of, walked off in 5 Ft of water,

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See *to* Alive, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 610 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: 583 c/o Faris (Degree or title) Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise
23c. DATE SIGNED: 7-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-24-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-24-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 14 2003

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 20 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2834
Local Reg. No. 387
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 127 E. Bannock 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 127 E. Bannock

3. NAME OF DECEASED (Type or Print)
a. (First): Rachel
b. (Middle): Ann
c. (Last): Brundage

4. DATE OF DEATH (Month) (Day) (Year): July 18, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 2, 1869
9. AGE (In years last birthday): 98 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): New Jersey
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel Husted — BIRTHPLACE: Unk.
14. MOTHER'S MAIDEN NAME: Rachel Gaskill — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Causes incident to age. — INTERVAL BETWEEN ONSET AND DEATH: 4 Days.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): assoc. with dehydration
DUE TO (c): Electrolyte imbalance

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——, 1960, *to* July 18, 1967, *that I last saw the deceased alive on* July 17, 1967, *and that death occurred at* ——— *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert Frazier 176 M.D.
23b. ADDRESS: 2010 N Cole Rd Boise,
23c. DATE SIGNED: July 18, '67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/20/67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer by [signature]
25. EMBALMER: [signature] — LICENSE NO. E-422

FIRM NAME: McBrathey-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63022

JUL 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2835
Local Reg. No. 400
Reg. Dist. No. 370

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1620 North 7th Street

3. NAME OF DECEASED (Type or Print)
a. (First): MANDA
b. (Middle): S.
c. (Last): KNUDSEN

4. DATE OF DEATH: July 18, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Feb. 14, 1877

9. AGE (In years last birthday): 90
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Norway

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ingebrigt Ingebrigtson
BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Maria Regina (Unknown)
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-07-8219

17. INFORMANT'S OWN SIGNATURE: Mrs Alvin S Hultgren, Jr
ADDRESS: 1820 W. Jefferson Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary heart attack
INTERVAL BETWEEN ONSET AND DEATH: Few hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fx hip left

19a. DATE OF OPERATION: July 6-67

19b. MAJOR FINDINGS OF OPERATION: Fx hip left

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): at home 01

21c. (CITY, TOWN, OR TOWNSHIP) 13 Boise (COUNTY) 011 Ada (STATE) Idaho

21d. TIME OF INJURY (Month) July (Day) 6 (Year) 67 (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?: Pt fell at home

22. *I hereby certify that I attended the deceased from* July 6, 1967, *to* July 18, 1967, *that I last saw the deceased alive on* July 18, 1967, *and that death occurred at* 7 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: James Coughlin 109 (Degree or title) MD 1

23b. ADDRESS: 1015 N 8th St

23c. DATE SIGNED: July 20 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-21-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-26-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Howell Mahoney

LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

AUG - 1 1967

STATE OF IDAHO

State File No. 2836
Local Reg. No. 407
Reg. Dist. No. 370

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Valley Convalescent

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 011 Boise
d. STREET ADDRESS (If rural, give location) 107 Wheeler

3. NAME OF DECEASED (Type or Print)
a. (First) Austin
b. (Middle) 332 L.
c. (Last) Knox

4. DATE OF DEATH (Month) (Day) (Year) July, 19, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 2
8. DATE OF BIRTH September 21, 1874
9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Moreson, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Allen Eathen Knox — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Mary Utley — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Orville L. Knox — ADDRESS Boise, Ida

18. CAUSE OF DEATH 4500
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of skin

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/5, 1967, *to* 7/19, 1967, *that I last saw the deceased alive on* 8/23/6, 1967, *and that death occurred at* 3:20 am *m., from the causes and on the date stated above.*

23a. SIGNATURE Allsheny 095 (Degree or title), McDI
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED 7/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 22, 1967
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Ada, Idaho

DATE REC'D BY LOCAL REG. 7-31-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Conway Grant — LICENSE NO. E478
FIRM NAME: Relyea Mortuary Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2837
Local Reg. No. 110
Reg. Dist. No. 371

BIRTH NO.

JUL 25 1967 1-01

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 ADA.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (In this place): 156 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing. 370
d. STREET ADDRESS (If rural, give location): Box 451.

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): W.
c. (Last): HARRIS

4. DATE OF DEATH: (Month) 7 (Day) 19 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: 10-6-94

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Bartender.

10b. KIND OF BUSINESS OR INDUSTRY: 23 Same

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Thomas J Harris
BIRTHPLACE: Calif.

14. MOTHER'S MAIDEN NAME: Nellie M Heyward
BIRTHPLACE: Missouri.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW 1 3

16. SOCIAL SECURITY NO.: 518 07 40 41

17. INFORMANT'S OWN SIGNATURE: John D Stark
ADDRESS: VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1532

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: I Week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Anastomotic leak in colon — I Week

DUE TO (c) Carcinomata of left colon and appendix

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ruptured appendix

19a. DATE OF OPERATION: 5-23-67

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of L. colon; carcinoma of appendix

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
VA

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I ~~hereby certify that I~~ attended the deceased from* 2-13, 19 67, *to* 7-19-67, 19 ~~*and that I last saw the deceased alive on*~~ ~~*19*~~ ~~*and that death occurred at*~~ 10:20AM *m., from the causes and on the date stated above.*

23a. SIGNATURE: J. K. Helferty
597 J. K. HELFERTY, M.D. (Degree or title)

23b. ADDRESS: VA Center, Boise, Idaho

23c. DATE SIGNED: 7-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7/21/67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-25-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Earl Waggoner

LICENSE NO.: E-422

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2838
Local Reg. No. 404
Reg. Dist. No. 370

RECE

BIRTH NO.

AUG - 1 1967

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8515 Fairview 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 8515 Fairview

3. NAME OF DECEASED (Type or Print)
a. (First) RAYMOND
b. (Middle) C.
c. (Last) KING

4. DATE OF DEATH (Month) July (Day) 26, (Year) 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced

8. DATE OF BIRTH Jan. 21, 1890

9. AGE (In years last birthday) 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY ---

11. BIRTHPLACE (State or foreign country) Huntington, Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alva King
BIRTHPLACE Indiana

14. MOTHER'S MAIDEN NAME Rose Addie
BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes
(If yes, give war or dates of service) WWI 3

16. SOCIAL SECURITY NO. 344-03-3535

17. INFORMANT'S OWN SIGNATURE From VA records J. Richard Reed
ADDRESS Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9290

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Asphyxiation by Drowning,

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Intoxicated, stumbled into a small water ditch on face. Blood Alcohol Lab test, 235 MG.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Brief

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident.

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 11P m., *from the causes and on the date stated above.*

23a. SIGNATURE 583 E. Paris (Degree or title) Coroner 7

23b. ADDRESS 3720 Meadow Drive, Boise,

23c. DATE SIGNED 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 25, '67

24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery

24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 7-28-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Howell M. Summers

LICENSE NO. E-409

FIRM NAME SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2839
Local Reg. No. 489
Reg. Dist. No. 370

BIRTH NO.

AUG - 2 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 4 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 6515 Fairview Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Patrick b. (Middle) M. c. (Last) McCarty

4. DATE OF DEATH (Month) (Day) (Year): July 21, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 15, 1895

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Law enforcement 08

10b. KIND OF BUSINESS OR INDUSTRY: Retired lawman

11. BIRTHPLACE (State or foreign country): Babb, Montana

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: No Record
BIRTHPLACE: No Record

14. MOTHER'S MAIDEN NAME: No Record
BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW1 3

16. SOCIAL SECURITY NO.: 574-03-7146

17. INFORMANT'S OWN SIGNATURE: Ruth N. Roberts
ADDRESS: Boise, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7950

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute abdominal disease — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) not known more specific diagnosis
(c) Kidney infection

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Previous Cerebrovascular Thrombosis — 5 yr.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* July 21, 1967, *that I last saw the deceased alive on* July 19, 1967, *and that death occurred at* 4P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert Thayer (Degree or title) M.D.

23b. ADDRESS: 2010 N Cole Rd Boise

23c. DATE SIGNED: 7-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 25, 1967

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Ada Idaho

DATE REC'D BY LOCAL REG.: 8-1-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Ted O. Gibson

LICENSE NO.: E-504

FIRM NAME: Relyea Mortuary
Boise, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2840
Local Reg. No. 476
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG - 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-21
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hosp. 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1115 Washington St.

3. NAME OF DECEASED (Type or Print): a. (First) Lyda b. (Middle) G. c. (Last) Martin

4. DATE OF DEATH: (Month) July (Day) 21 (Year) 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: Nov. 12, 1890

9. AGE (In years last birthday): 76 IF UNDER 1 YEAR Months: 8 Days: 9 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Olney, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: E. A. Gardner BIRTHPLACE: Olney, Ill.

14. MOTHER'S MAIDEN NAME: Amanda Liebhart BIRTHPLACE: Greenville, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 518-28-6484

17. INFORMANT'S OWN SIGNATURE: Mrs Beulah M. Gerbus ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Basilar Artery Thrombosis 3332X — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/29, 1967, *to* 7/21, 1967, *that I last saw the deceased alive on* 7/21, 1967, *and that death occurred at* 5:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: 654 Walter H. Wilson (Degree or title) MD

23b. ADDRESS: 425 W Bannock Boise

23c. DATE SIGNED: 7/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 25, 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett Cemetery

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: 8-3-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Walter F Potter LICENSE NO.: E 445

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2841
Local Reg. No. 401
Reg. Dist. No. 370

RECEIVED JUL 28 1967

BIRTH NO. 120

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital): Boise
c. LENGTH OF STAY (In this place): 20 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 722 North Liberty 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 722 North Liberty

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Holtby	Fred	Skelton	July 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Sept. 20, 1869	97				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Cattle	Seamar, England	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Skelton	England	Mary Holtby	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	518-54-1700	Nancy E. Skelton	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*	INTERVAL BETWEEN ONSET AND DEATH
(a)	Uremia	2 weeks
DUE TO (b)	Chronic nephritis	10 years
DUE TO (c)		

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan 1st, 1967, *to* July 22, 1967, *that I last saw the deceased alive on* July 22, 1967, *and that death occurred at* 4:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Reese Board MD	Boise, Idaho	July 24-1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-25-67	Dry Creek	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-26-67	Myrtle Palmer	Daniel G. Gibson	E-400

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Gibson Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2842
Local Reg. No. 422
Reg. Dist. No. 370

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Glenns Ferry 200
d. STREET ADDRESS (If rural, give location): 1 mile East of Glenns Ferry

3. NAME OF DECEASED (Type or Print)
a. (First): KARL
b. (Middle):
c. (Last): LEIMGRUBER

4. DATE OF DEATH (Month) (Day) (Year): July 23, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: Sept. 17, 1888
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fruit Grower 04
10b. KIND OF BUSINESS OR INDUSTRY: Apple Orchards
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Hammett, I

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Hammett

18. CAUSE OF DEATH 334X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Comatose condition from Arsenal Vascular Lesion — 2 years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 20, 1965, *to* 7-23, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 318 W.D.
23b. ADDRESS: 401 N. Orchard Boise Idaho
23c. DATE SIGNED: 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/27/67
24c. NAME OF CEMETERY OR CREMATORY: Glenn Rest Cemetery
24d. LOCATION (City, town, or county) (State): Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.: 8-7-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature] LICENSE NO. E-410
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2843
Local Reg. No. 402
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 423 Main

3. NAME OF DECEASED (Type or Print)
a. (First): Tillie
b. (Middle): Coltida
c. (Last): Villeneuve

4. DATE OF DEATH (Month) (Day) (Year): July 24, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 23, 1912
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk 25
10b. KIND OF BUSINESS OR INDUSTRY: State Liquor Disp.
11. BIRTHPLACE (State or foreign country): Hammett, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Crispino — BIRTHPLACE: Italy
14. MOTHER'S MAIDEN NAME: Erminia Macarrato — BIRTHPLACE: Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Eugene Villeneuve — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 157X CA pancreas — INTERVAL BETWEEN ONSET AND DEATH: 18 Mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10/31/66
19b. MAJOR FINDINGS OF OPERATION: Tumor pancreas
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1958, to July 24, 1967, that I last saw the deceased alive on July 24, 1967, and that death occurred at 7 P m., from the causes and on the date stated above.*

23a. SIGNATURE: James H Hemley MD 216 (Degree or title)
23b. ADDRESS: 850 S Latah
23c. DATE SIGNED: 25 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-27-67
24c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: 7-26-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 17 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Claussey

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2844
Local Reg. No. 405
Reg. Dist. No. 370

BIRTH NO.

AUG - 1 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 20 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 1901 S. Phillippi

3. NAME OF DECEASED (Type or Print)
a. (First) Alice Margaret
b. (Middle)
c. (Last) Harris

4. DATE OF DEATH (Month) July (Day) 24 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 7 1912
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Proctor, Minn.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edward Ruidl — BIRTHPLACE Wisc.
14. MOTHER'S MAIDEN NAME Catherine Zeigler — BIRTHPLACE Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE X Fred J Harris — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Lung, — INTERVAL BETWEEN ONSET AND DEATH 6 mos.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/15, 1963, *to* 7/24, 1967, *that I last saw the deceased alive on* 7/23, 1967, *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) O J Clohessy, M.D. 095
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED 7/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 27 67
24b. DATE July 27 67
24c. NAME OF CEMETERY OR CREMATORY Cloverdale
24d. LOCATION (City, town, or county) (State) Boise, Ida.

DATE REC'D BY LOCAL REG. 7-28-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Daniel G. Gibson — Daniel G. Gibson
LICENSE NO. 400

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 25 2000

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2845
Local Reg. No. 415
Reg. Dist. No. 370

BIRTH NO. 67-6196

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2023 Penninger Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Jamie b. (Middle) Lee c. (Last) Wingate

4. DATE OF DEATH: (Month) (Day) (Year): July 24, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant /

8. DATE OF BIRTH: July 22, 1967

9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 2 / IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jimmy L. Wingate
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: X Sharon M. Hire
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X Jimmy L. Wingate
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7768

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity - birth wt 1½ lbs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify, that I attended the deceased from* July 22, 1967, *to* July 24, 1967, *that I last saw the deceased alive on* July 24, 1967, *and that death occurred at* 11:55 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE: Bert L. Reed, MD. 717 (Degree or title)

23b. ADDRESS: 403 Fort Street, Boise, Ida

23c. DATE SIGNED: 7-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7/26/67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 8-1-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: G. W. Waters

LICENSE NO.: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2846
Local Reg. No. 2846
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG - 3 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau of
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1307 Grove Street

3. NAME OF DECEASED (Type or Print): a. (First) Rudolph b. (Middle) c. (Last) Rudelich

4. DATE OF DEATH: July 24, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Aug. 30, 1927

9. AGE (In years last birthday): 39
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Disabled 28

10b. KIND OF BUSINESS OR INDUSTRY: Disabled

11. BIRTHPLACE (State or foreign country): Winton, Wyo.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Rudelich
BIRTHPLACE: Yugoslavia

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Anthony F. Rudelich
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypoproteinemia-Anemia — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks this attack.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Bowel hemorrhage — 1954

DUE TO (c) Ulcerative Ileo Colitis — 1954

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

5722

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Ulcerated Colon & Toxic Megacolon

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/26, 1966, *to* 7/24, 1967, *that I last saw the deceased alive on* 7/24, 1967, *and that death occurred at* 7:10 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Everett N. Jones 267 (Degree or title): MD

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 7/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-28-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-1-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Daniel G. Gibson

LICENSE NO.: E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2847
Local Reg. No. 411
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 011 — AUG - 3 1967 — 3-21

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — Bureau

c. LENGTH OF STAY (in this place): 3 weeks

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 812 Alturas — 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — 011

d. STREET ADDRESS (If rural, give location): 1614 N. 9th St.

3. NAME OF DECEASED (Type or Print): a. (First) ALICE — b. (Middle) N. — c. (Last) MURPHY

4. DATE OF DEATH: (Month) (Day) (Year): July 24, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: July 31, 1892

9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Elwood, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Willis Law — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Melisia Bronston — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-24-5612

17. INFORMANT'S OWN SIGNATURE: Mrs Velma Shaw — ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertensive Heart Disease — 3 yrs.

DUE TO (c) Arteriosclerosis Gen.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Fracture Left Leg — 2 mo.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb. 14, 1964, *to* 7-24, 1967, *that I last saw the deceased alive on* 7-13, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Carl B. Knutson, M.D. (Degree or title) — **23b. ADDRESS**: Boise Idaho — **23c. DATE SIGNED**: 7-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: July 27, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Cloverdale Memorial Park — **24d. LOCATION** (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 8-1-67 — **REGISTRAR'S SIGNATURE**: Myrtle Palmer

25. EMBALMER: G. W. Waters — **LICENSE NO.**: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2848
Local Reg. No. 406
Reg. Dist. No. 370

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2514 Chitwood Way

3. NAME OF DECEASED (Type or Print)
a. (First): LEONE
b. (Middle): B.
c. (Last): SOLLENDER

4. DATE OF DEATH (Month) (Day) (Year): July 24, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: June 14, 1916
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Penn Barton — BIRTHPLACE: Rincohn, Utah
14. MOTHER'S MAIDEN NAME: Margaret Stanley — BIRTHPLACE: Douglas, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 519-01-2175
17. INFORMANT'S OWN SIGNATURE: Gene C. Sollender — ADDRESS: 2514 Chitwood Way, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute cardiac dilatation & pulmonary edema. - Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 1:11 a m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 654 (Degree or title) MD.
23b. ADDRESS: 425 W Bannock Boise
23c. DATE SIGNED: 7/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify): cremation
24b. DATE: July 27 '67
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Crematory
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 7-28-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature] — LICENSE NO.: E-410

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG - 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 6 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 18 1987

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2849
Local Reg. No. 470
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG - 3 1967

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
c. LENGTH OF STAY (in this place) D O A
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address of location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) 711 North 9th Box 608

3. NAME OF DECEASED (Type or Print)
a. (First) DEOLA
b. (Middle) JEAN
c. (Last) CLEMENTS

4. DATE OF DEATH (Month) 7 (Day) 24 (Year) 67

5. SEX F

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Feb. 15, 1931

9. AGE (In years last birthday) 36 | If under 1 year: Months 5, Days 9 | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesladv Western Auto

10b. KIND OF BUSINESS OR INDUSTRY Hardware

11. BIRTHPLACE (State or foreign country) Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Darold Christinsen

BIRTHPLACE 25 Aberdeen, Idaho

14. MOTHER'S MAIDEN NAME Jessie Rever

BIRTHPLACE New Market, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

(If yes, give war or dates of service) No 0

16. SOCIAL SECURITY NO. 519-30-8248

17. INFORMANT'S OWN SIGNATURE x Vern C. Clements

ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8214

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Trauma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Motorcycle Accident

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE / (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) 13 King Hill (COUNTY) 200 (STATE) Idaho

21d. TIME OF INJURY (Month) 7 (Day) 24 (Year) 67 (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Tire of Motorcycle blew out.

22. *I hereby certify that I attended the deceased from* 7-24, 1967, *to* 7-24, 1967, *that I last saw the deceased alive on* DOA 1519 ER *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 704 Al Kuykendall

23b. ADDRESS 401 Idaho St

23c. DATE SIGNED 7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 7/27/67

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill

24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. 8-1-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Lucy M. Flahiff

LICENSE NO. E393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2850
Local Reg. No. 474
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG - 3 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 001 — 3-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Walla Walla
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Walla Walla 555
d. STREET ADDRESS (If rural, give location): 117½ East Alder

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PETE	D.	LEWANDOWSKI	July 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	widowed 2	Oct. 12, 1887	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29	Saw Filer	Howard County, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Stanslaw Lewandowski	Russia	Lucy Rezinsky	Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	539-07-0241	family record J. Richard Reed	Walla Walla, Wash.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebrovascular Accident	30 min.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hypertension	unknown
DUE TO (c)		unknown
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes	

33 X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 21 July, 1967, *to* 25 July, 1967, *that I last saw the deceased alive on* 25 July, 1967, *and that death occurred at* 12:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] 654 (Degree or title) M.D.	425 W Bannock Boise	7/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal 3	7-25-67	Dayton City Cemetery	Dayton Columbia Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-3-67	Myrtle Palmer	[signature]	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2851
Local Reg. No. 403
Reg. Dist. No. 370

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 60 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5605 Kootenai 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 5605 Kootenai

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Guy c. (Last) Wartman

4. DATE OF DEATH (Month) (Day) (Year) July 25, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec 11, 1906
9. AGE (In years last birthday) 60 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY Automative
11. BIRTHPLACE (State or foreign country) Meridian, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Wartman
BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Mary Olive Caster
BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-09-1596
17. INFORMANT'S OWN SIGNATURE K Eugene Wartman
ADDRESS Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Severe Chest pains, night before, and just before death. Hours.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See *to* Alive, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 6 IOP m., *from the causes and on the date stated above.*

23a. SIGNATURE 583 E. D. Parris (Degree or title) Coroner
23b. ADDRESS 3720 Meadow Drive, Boise,
23c. DATE SIGNED 7-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 28, 1967
24c. NAME OF CEMETERY OR CREMATORY Terrace Lawn Cemetery
24d. LOCATION (City, town, or county) Boise, Ada, (State) Idaho

DATE REC'D BY LOCAL REG. 7-27-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Conway Mortuary
LICENSE NO. E428
FIRM NAME: Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Max Bell

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2852
Local Reg. No. 2853
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada — AUG 1 1 1967 — 148
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise — Bureau of Vital Statistics — LENGTH OF STAY (in this place) 48 48 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 4428 Denton

3. NAME OF DECEASED (Type or Print): a. (First) IDA — b. (Middle) PEARL (Cramer) — c. (Last) Webster

4. DATE OF DEATH: (Month) July (Day) 26, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 8, 1918

9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: James Cramer — BIRTHPLACE: Joplin, Missouri

14. MOTHER'S MAIDEN NAME: Maude McGrew — BIRTHPLACE: Honey Creek, Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none 0

16. SOCIAL SECURITY NO.: 878X

17. INFORMANT'S OWN SIGNATURE: Lorraine C Webster — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Suspected Drug Intoxication — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): not determined

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1961, *to* July 25, 1967, *that I last saw the deceased alive on* July 25, 1967, *and that death occurred at* 4:00a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Max H. Bell, MD (Degree or title) — **23b. ADDRESS**: Boise, Idaho — **23c. DATE SIGNED**: 8/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 7-27-67 — **24c. NAME OF CEMETERY OR CREMATORY**: Morris Hill Cemetery — **24d. LOCATION** (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-10-67 — REGISTRAR'S SIGNATURE: Myrtle Palmer — EMBALMER: Conway Grant — LICENSE NO.: E978

FIRM NAME: RELYEA CHAPEL, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 15 1967

JAN 9 - 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2853
Local Reg. No. 427
Reg. Dist. No. 370

RECEIVED AUG 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits or township): Boise
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1802 N. 18th St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1802 N. 18th St.

3. NAME OF DECEASED (Type or Print): a. (First) Ada b. (Middle) May c. (Last) McGuffin

4. DATE OF DEATH: (Month) (Day) (Year): July 27, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: April 6, 1878

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired merchant

10b. KIND OF BUSINESS OR INDUSTRY: 22 retail

11. BIRTHPLACE (State or foreign country): Hubbell, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Eli A. Barton
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Priscilla E. Weaver
BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-07-8813

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: A Gertrude McGuffin

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease. — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December, 19 63 *to* _____, 19____, *that I last saw the deceased alive on* 5-24-67, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Quentin E Howard MD

23b. ADDRESS: 401 Idaho St.

23c. DATE SIGNED: 8-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7/31/67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-7-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Paul Waggoner

LICENSE NO.: E-422

FIRM NAME: McBratney-Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2854
Local Reg. No. 112
Reg. Dist. No. 371

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 173
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
LENGTH OF STAY (in this place): 73 Days.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): V. A. Hospital Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise. 011
d. STREET ADDRESS (If rural, give location): Idaho State Soldiers Home.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Leonard	E.	ANDERSON.	7	28	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	7-11-07	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Laborer. 06	Same	Utah.	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oscar Anderson.	Utah	Regina Rosenvinge.	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 2	529 10 6665	John E. Anderson	VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis, generalized.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-24-67	Occlusion right superficial femoral artery.	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I hereby certify that I attended the deceased from 5-16, 19 67, to 7-28, 19 67, and that death occurred at 4:20 PM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. J. BUNGARD, M.D.	VA Center, Boise, Idaho	7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 2, 1967	Washington Heights	Ogden Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-3-67	Myrtle Palmer	Lowell M. Summers	E 509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2855
Local Reg. No. 115
Reg. Dist. No. 371

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise-
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Table Rock Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 4345 Adams Street

3. NAME OF DECEASED (Type or Print)
a. (First): Susan
b. (Middle): M.
c. (Last): Hudson

4. DATE OF DEATH (Month) July (Day) 28 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 5, 1946
9. AGE (In years last birthday): 21 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurses Aid 13
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Talarowski — BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Ruby L. McPherson — BIRTHPLACE: Eagle, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 569-58-8719
17. INFORMANT'S OWN SIGNATURE: X Henry A. Talarowski — ADDRESS: 4345 Adams Street Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by Carbon-Monoxide Poison in car. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c) Family Troubles, Seperation. Despondent. — 3 Weeks

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

9731

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 011 (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* P 9P *m., from the causes and on the date stated above.*

23a. SIGNATURE: 583 E. D. Perio (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: 8-4-67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Aug. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY: Joplin Cemetery
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 8-8-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Howell D. Demaray — LICENSE NO.: E 509

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Summers Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Clossey
848 LaCassa Drive
343-9575

Certificate of Death

STATE OF IDAHO

State File No. 2856
Local Reg. No. 408
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG - 2 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2212 North 19th. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2212 North 19th.

3. NAME OF DECEASED (Type or Print)
a. (First): Della
b. (Middle): Mary
c. (Last): Sampson

4. DATE OF DEATH (Month) (Day) (Year): July 29, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 5, 1893
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Alterations 06
10b. KIND OF BUSINESS OR INDUSTRY: Alterations
11. BIRTHPLACE (State or foreign country): Grinnell, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry L. Todd — BIRTHPLACE: U.S.A.
14. MOTHER'S MAIDEN NAME: Johnston — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Doris E Walter — ADDRESS: Maryland

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4214

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Valvular Heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/7, 1967, *to* 7/29, 1967, *that I last saw the deceased alive on* 7/26, 1967, *and that death occurred at* 5:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Clossey 088, M.D.
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 8/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-2-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Mill
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-1-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Daniel G. Gibson — LICENSE NO.: E-400

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 3 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar [illegible] district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2857
Local Reg. No. 417
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG - 4 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2409 North 25th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2409 North 25th

3. NAME OF DECEASED (Type or Print)
a. (First): GRACE
b. (Middle): EVELYN
c. (Last): FARNHAM

4. DATE OF DEATH (Month) (Day) (Year): July 29, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: Dec. 6, 1886

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife, retired

10b. KIND OF BUSINESS OR INDUSTRY: 01

11. BIRTHPLACE (State or foreign country): Anoka, Minnesota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Brundage
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: no record
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Lewis B. Higgins
ADDRESS: 2409 N. 25 Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis 332 X

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Cerebral Arteriosclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-7, 1967 *to* July 28, 1967, *that I last saw the deceased alive on* 4-15, 1967, *and that death occurred at* 11:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. C. Johnson 261 (Degree or title): MD

23b. ADDRESS: Boise Ida

23c. DATE SIGNED: 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: July 31, 1967

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 8-3-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: J. Richard Reed

LICENSE NO.: E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 21 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2858
Local Reg. No. 440
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kuna 010
d. STREET ADDRESS (If rural, give location): 107 Franklin

3. NAME OF DECEASED (Type or Print)
a. (First): Sophia
b. (Middle): M. 332
c. (Last): Fiss

4. DATE OF DEATH (Month) (Day) (Year): July 29, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: March 28, 1873
9. AGE (In years last birthday): 94 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Charles City, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Fiss — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Elizabeth Achenbach — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-54-5243 T
17. INFORMANT'S OWN SIGNATURE: Elsie Fiss — ADDRESS: Kuna

18. CAUSE OF DEATH 4221
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Vascular Disease — 20 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Marked Senility — 10 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/14/65, 19__, *to* 7/29/67, 19__, *that I last saw the deceased alive on* 7/29/67, 19__, *and that death occurred at* 10:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 516 (Degree or title)
23b. ADDRESS: 1703 Hill Road, Boise
23c. DATE SIGNED: 8/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-1-67
24c. NAME OF CEMETERY OR CREMATORY: Kuna Cemetery
24d. LOCATION (City, town, or county) (State): Kuna, Idaho

DATE REC'D BY LOCAL REG.: 8-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-366
FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 27 1974

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2859
Local Reg. No. 447
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 010

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian

c. LENGTH OF STAY (in this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 234 E. Williams St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 234 E. Williams St. 010

d. STREET ADDRESS (If rural, give location): Meridian, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) Clyde; b. (Middle) Raymond; c. (Last) Ryker

4. DATE OF DEATH (Month) (Day) (Year): July 29, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 29, 1909

9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Equipment operator 08

10b. KIND OF BUSINESS OR INDUSTRY: Ada County Road Dept.

11. BIRTHPLACE (State or foreign country): Parsons, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John C. Ryker — BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Susan Mc Clure — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-01-8095

17. INFORMANT'S OWN SIGNATURE: Helen R. Ryker — ADDRESS: Meridian

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary arteriosclerosis — unk.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* never attended deceased *, 19__, to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at* 8:00A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lee 6242 Pulley MD

23b. ADDRESS: 925 E 1st Meridian

23c. DATE SIGNED: 1 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-1-67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-16-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Leo Jerred

LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2860
Local Reg. No. 442
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian 010
d. STREET ADDRESS (If rural, give location): 20 E. Ada St.

3. NAME OF DECEASED (Type or Print)
a. (First): Nora
b. (Middle): B.
c. (Last): Chamness

4. DATE OF DEATH (Month) (Day) (Year): July 30, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 29, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Shoals, Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Shelton Vice — BIRTHPLACE: Unk
14. MOTHER'S MAIDEN NAME: Mary Devine — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 534-10-7143
17. INFORMANT'S OWN SIGNATURE: Doris Wenzel — ADDRESS: Meridian

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Chronic brain syndrome — 2 yrs
DUE TO (c): Cerebral arteriosclerosis — unk

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: fractured (R) hip — 1 week

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1964, 19__, *to* July, 1967 *that I last saw the deceased alive on* 29 July, 1967, *and that death occurred at* 3:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lee G. Pulley MD 6240
23b. ADDRESS: 925 E 1st Meridian
23c. DATE SIGNED: 1 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 8-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Copple 66-11478
403 Fort

RECEIVED
AUG - 4 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2861
Local Reg. No. 478
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): D O A
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1223 East State 010
d. STREET ADDRESS (If rural, give location): Boise, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): LYNN
c. (Last): ALYK

4. DATE OF DEATH (Month) (Day) (Year): July 31 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): infant
8. DATE OF BIRTH: Dec. 13, 1966
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 7 Days 18; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: George Alyk — BIRTHPLACE: HolyYoke Mass.
14. MOTHER'S MAIDEN NAME: Thelma Wilks — BIRTHPLACE: Burley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: Thelma Alyk — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 12 Hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): E. Coli
DUE TO (c): Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: None

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/31, 1967, *to* 7/31, 1967, *that I last saw the deceased alive on* 7/31, 1967, *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23a. SIGNATURE: B. J. Copple 102 (Degree or title) MD
23b. ADDRESS:
23c. DATE SIGNED: 8/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-3-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E 478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Relyea Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 21 1986

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-7205 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2862
Local Reg. No. 419
Reg. Dist. No. 370

BIRTH NO.

AUG 8 - 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, 011
d. STREET ADDRESS (If rural, give location): Route #3 Maple Grove Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Betty	Zane	Bivins	7-31-67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	7-30-67				22	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant	Infant 02	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Donald Ray Bivins	Oklahoma	Pamla Joyce Nelson	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	No.	Mrs Don Bivins	Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7766

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
F.K. Root MD	Boise	8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-7-67	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-4-67	Myrtle Palmer	Eldon T. Pearson Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Gibson Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2863
Local Reg. No. 116
Reg. Dist. No. 371

BIRTH NO.

RECEIVED AUG 10 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 ADA 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE, IDAHO.
LENGTH OF STAY (in this place) 7 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA CENTER, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE OREGON 38 b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ONTARIO. 555
d. STREET ADDRESS (If rural, give location) P.O. BOX 726:

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Baudelio	C	HERRERA.	7	31	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	5-20-25	42				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY Same
11. BIRTHPLACE (State or foreign country) Trinidad, Colo.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jesus Herrera	Mexico	Jesusita Contreras	Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW 2
16. SOCIAL SECURITY NO. 465 34 2613
17. INFORMANT'S OWN SIGNATURE John B. Clark ADDRESS VA HOSPITAL RECORDS, BOISE, IDAHO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5227 ACUTE PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH 1 HR.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (NOT DETERMINED BY GROSS AUTOPSY)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES XXX NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I attended the deceased from 7-24, 1967, to 7-31, 1967, that I last saw the deceased alive on [illegible], 19[illegible] and that death occurred at 5:30 Pm., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Glenn Q Voyles GLENN Q VOYLES, M.D.	VA CENTER, BOISE, IDAHO	8-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8-1-67		Ontario, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-8-67	Myrtle Palmer	Dale McMurtrey	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2864
Local Reg. No. 13
Reg. Dist. No. 300

Certificate of Death

STATE OF IDAHO

RECEIVED
JUL 12 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Meadows
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Meadows 020
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print)
a. (First): LAWRENCE
b. (Middle): M.
c. (Last): STOVER

4. DATE OF DEATH (Month) July (Day) 4 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced 4
8. DATE OF BIRTH: April 12, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months 2, Days 22 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Weiser, Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Joseph Stover — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Clara — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: + Alton L. Stover — ADDRESS: Weiser, Idaho

18. CAUSE OF DEATH 466X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Emboli, bilat

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) thrombosis, splenic vein
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Autopsy *to* Only, *19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K. E. Brouwer 147
23b. ADDRESS: P.O. Drawer D, Nampa Idaho
23c. DATE SIGNED: 7/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 7-7-67
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cementry
24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: 7-8-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Marshall Dickerson Jr.
LICENSE NO.: E-464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2865
Local Reg. No. 184
Reg. Dist. No. 510

Certificate of Death

RECEIVED
JUL 18 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Nurs. Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 1241 No. Main St.

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): ELLEN 294
c. (Last): OWSLEY

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Apr. 25, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Rodney, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Parks — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Mary E. ProLunier — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: L E Owsley — ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic cerebral vascular disease, recurrent cerebral thrombosis, chronic brain syndrome
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) mint paralysis & severe decubitus
DUE TO (c) of back & hips

INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1955, 19__, *to* 7-2, 1967, *that I last saw the deceased alive on* 6-26-, 1967, *and that death occurred at* 4P *m., from the causes and on the date stated above.*

23a. SIGNATURE: David C. Miller 362 (Degree or title) M.D.
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 7-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gdns.
24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: 7-10-67
REGISTRAR'S SIGNATURE: Sally Kellogg
25. EMBALMER: George W. Knapp
LICENSE NO.: 409

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2866
Local Reg. No. 183
Reg. Dist. No. 511

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 030 Bannock 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCammon
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCammon 030
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) EVAN
b. (Middle) LEE
c. (Last) ANDERSON

4. DATE OF DEATH (Month) (Day) (Year) July 2, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH Jan. 29, 1958
9. AGE (In years last birthday) 9 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY Public school
11. BIRTHPLACE (State or foreign country) Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Keith G. Anderson — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Jean Miracle — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) XXXX
16. SOCIAL SECURITY NO. XXX
17. INFORMANT'S OWN SIGNATURE Keith G. Anderson — ADDRESS McCammon, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suffocation - asphyxiation — INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) (Drowning)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm 02
21c. (CITY, TOWN, OR TOWNSHIP) 13 — 030 (COUNTY) Bannock — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-2-67 3 P m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Accidental Drowning in Pond.

22. *I hereby certify that I attended the deceased from —, 19—, to —, 19—, that I last saw the deceased alive on* 7-2, 1967, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE Burton J. John 583 (Degree or title) Coronett
23b. ADDRESS Bannock Co. Idaho
23c. DATE SIGNED 7-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 5, 1967
24c. NAME OF CEMETERY OR CREMATORY McCammon Cemetery
24d. LOCATION (City, town, or county) (State) McCammon, Bannock, Idaho

DATE REC'D BY LOCAL REG. JUL 10 1967
REGISTRAR'S SIGNATURE Sally Kelly
25. EMBALMER Conway Grant
LICENSE NO. E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2867
Local Reg. No. 183
Reg. Dist. No. 510

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

JUL 18 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 739 North 7th Avenue 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 739 North 7th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): ALBERT
b. (Middle):
c. (Last): BUCHANAN

4. DATE OF DEATH (Month) July (Day) 3 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: January 26, 1900
9. AGE (In years last birthday): 67 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Porter 06
10b. KIND OF BUSINESS OR INDUSTRY: Barber Shops
11. BIRTHPLACE (State or foreign country): Savannah, Illinois
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: James Buchanan — BIRTHPLACE: no data
14. MOTHER'S MAIDEN NAME: Henrietta (no data) — BIRTHPLACE: no data

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: 519-03-8939
17. INFORMANT'S OWN SIGNATURE: Juanita Johnson — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH 241X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Asthmatic
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to* July 3, 1967, *that I last saw the deceased* ~~dead~~ *on* July 3, 1967, *and that death occurred at* 7:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE: Burton John 583 4 Carouse (Degree or title)
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: July 6, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: 7-10-67
REGISTRAR'S SIGNATURE: Sally Kellogg
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2868
Local Reg. No. 194
Reg. Dist. No. 511

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 031
a. COUNTY Bannock JUL 21 1967 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello, Idaho
c. LENGTH OF STAY (If in hospital or institution) 3 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Daughter Home 1424 Pershing.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho 040 b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier, Idaho
d. STREET ADDRESS (If rural, give location) 440 Huff

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) Lessly 000 c. (Last) Hess

4. DATE OF DEATH (Month) (Day) (Year) July 5, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct 14, 1891
9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work in dealing most of working life, even if retired) Retired Employee
10b. KIND OF BUSINESS OR INDUSTRY U.P. Railroad
11. BIRTHPLACE (State or foreign country) Georgetown Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John H. Hess 10 BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Susan Sheffield BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 712-07-0334
17. INFORMANT'S OWN SIGNATURE Mrs. George L Hess ADDRESS Montpelier Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerotic Cardio-Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH 4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) infarction
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
(2) Pul moving drughty sense — yes
(3) Probable — Carcinoma of Lt. Lung — 4 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-27, 1967, *to* 7-5-, 1967, *that I last saw the deceased alive on* 7-1-67, 19__, *and that death occurred at* 1 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE D. Miller 362 (Degree or title) MDG
23b. ADDRESS Pocatello Idaho
23c. DATE SIGNED 7-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE July 7 1967
24c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery
24d. LOCATION (City, town, or county) (State) Georgetown Idaho

DATE REC'D BY LOCAL REG. JUL 18 1967
REGISTRAR'S SIGNATURE Sally Kellogg
25. EMBALMER Nile Matthews LICENSE NO. E359
FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2869
Local Reg. No. 193
Reg. Dist. No. 511

Certificate of Death

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BANNOCK 031 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello, Idaho
c. LENGTH OF STAY: 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BANNOCK Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs, Idaho 150
d. STREET ADDRESS (If rural, give location): 280 West 1 st. South

3. NAME OF DECEASED (Type or Print)
a. (First): Mabel
b. (Middle): L. 018
c. (Last): MONROE

4. DATE OF DEATH (Month) (Day) (Year): July 5 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Dec. 28, 1899
9. AGE (In years last birthday): 67 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Store clerk
10b. KIND OF BUSINESS OR INDUSTRY: 25
11. BIRTHPLACE (State or foreign country): Soda Springs, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James MONROE — BIRTHPLACE: Spanish Fork, Ut.
14. MOTHER'S MAIDEN NAME: Mary ANN Baird — BIRTHPLACE: FRANKLIN, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-07-6615A
17. INFORMANT'S OWN SIGNATURE: Viola L. Monroe — ADDRESS: Soda Springs Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9037

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Surgery for fractures of Hip.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes, Nephritis, Hypertension

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Fracture Hip
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Soda Springs, Hospital 13
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Soda Springs, 150 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 6-29-67 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Patient fell while in Hospital

22. *I hereby certify that I attended the deceased from* 6-29-67, 19__, *to* 7-5-67, 19__, *that I last saw the deceased alive on* 7-5-67, 19__, *and that death occurred at* 4:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 745 M.D.
23b. ADDRESS: 1352 East Center, Pocatello, Idaho
23c. DATE SIGNED: 7-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs Idaho

DATE REC'D BY LOCAL REG.: 7-14-67
REGISTRAR'S SIGNATURE: Lucy Kellogg
25. EMBALMER: Nile Matthews
LICENSE NO.: E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Whitman Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 9 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 9 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2870
Local Reg. No. 116
Reg. Dist. No. 570

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031 JUL 18 1967 115
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 15 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 928 North Grant St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello 031
d. STREET ADDRESS (If rural, give location) 928 North Grant St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	WILLIAM	AUSTIN	RANSOM	July	5	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	November 16, 1883	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Trenton, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James R. Ransom	Salt Lake City, Utah	Agnes E. Austin	Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-34-0378	Laura Ransom	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Diabetes, Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
		Pocatello	Bannock	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
			m.		

22. *I hereby certify that I attended the deceased from* 1959, *19*, *to* July 5, *19* 67, *that I last saw the deceased alive on* July 5, *1967*, *and that death occurred at* 8:00a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
248 RD Howard	M.D.	Pocatello, Idaho	July 6, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 8, 1967	Groveland cemetery	Bingham county Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JUL 13 1967	Lucy Kelly	C. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2871
Local Reg. No. 9991
Reg. Dist. No. 510

BIRTH NO.

JUL 27 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Convalscent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 730 West Benton Street

3. NAME OF DECEASED (Type or Print)
a. (First): JANE
b. (Middle): McKINZIE 294
c. (Last): DEAN

4. DATE OF DEATH (Month) (Day) (Year): July 7 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: August 13, 1872
9. AGE (In years last birthday): 94 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Logan Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George U. Smith — BIRTHPLACE: Etholy, England
14. MOTHER'S MAIDEN NAME: Matilda Farnes — BIRTHPLACE: Dagenham, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Gertrude Dean Neal — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease w/ congestive failure

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to July 7, 1967, that I last saw the deceased alive on July 7, 1967 and that death occurred at 7:35 pm., from the causes and on the date stated above.*

23a. SIGNATURE 356 (Degree or title): R.R.Merrell, MD — R.R. Merrell, MD
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: July 10, '67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 12, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: 7-25-67
REGISTRAR'S SIGNATURE: Sally Kellogg
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK ... OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

Howard

RECEIVED

STATE OF IDAHO

State File No. 2872
Local Reg. No. 187
Reg. Dist. No. 510

BIRTH NO.

JUL 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LIVING OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 031 Pocatello
d. STREET ADDRESS (If rural, give location) Route 3 South

3. NAME OF DECEASED (Type or Print)
a. (First) MARTHA R. PETTET
b. (Middle) 018
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) July 8, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH February 1, 1884
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Rural, Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William H. Potts — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Elizabeth Swann — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-12-8154
17. INFORMANT'S OWN SIGNATURE Elizabeth Jean Haselden — ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5411 Hemorrhage + Rupt. Duodenal ulcer — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Liver disease, pending microscopic

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Pocatello (COUNTY) Idaho (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr, 1967, *to* July 8, 1967, *that I last saw the deceased alive on* July 8, 1967, *and that death occurred at* 11 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE RC Howard MD 248 (Degree or title) M.D. 1
23b. ADDRESS Pocatello, Idaho
23c. DATE SIGNED July 10, 67

24a. BURIAL, CREMATION, REMOVAL (Specify) 2 Cremation
24b. DATE July 11, 1967
24c. NAME OF CEMETERY OR CREMATORY Aultorest Crematory
24d. LOCATION (City, town, or county) Ogden, Utah (State)

DATE REC'D BY LOCAL REG. JUL 13 1967
REGISTRAR'S SIGNATURE Sally Kellogg
25. EMBALMER Dean Hill
LICENSE NO. E-466

Federal Security Agency
United States Public Health Service
Form BH-63021
FIRM NAME: Sandberg-Hill Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2873
Local Reg. No. 789
Reg. Dist. No. 511

RECEIVED STATE OF IDAHO

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 031 JUL 1 8 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arimo 030
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ELIZA	CORDELIA	CAPELL	July 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed 2	Sept. 5, 1886	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Yellow Creek, N.Carolina	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Zeb Gunter	North Carolina	Elizabeth Myers	Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXX		Jannie E Capell	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4201 Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* June, 19 67, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Calvin Buhler 069 (Degree or title) M D		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
B			

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-12-67	Larry Kelley	Conway Grant	E478

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 15 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2874
Local Reg. No. 190
Reg. Dist. No. 516

RECEIVED
Bureau of Vital Statistics
JUL 18 1967

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 03 JUL 18 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Pocatello
c. LENGTH OF STAY IN THIS PLACE: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 1343 East Alameda Road

3. NAME OF DECEASED (Type or Print): a. (First) ARVIL b. (Middle) H. c. (Last) GOODRICH

4. DATE OF DEATH: (Month) July (Day) 9, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 27, 1917

9. AGE (In years last birthday): 49 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blocks Men's Store

10b. KIND OF BUSINESS OR INDUSTRY: & Ralston-Purina

11. BIRTHPLACE (State or foreign country): Bluebell, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alfred S. Goodrich 25

BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Sylvia Ann Hancock

BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Mr. Estar Goodrich ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Malignant lymphoma — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 20, 19 51, *to* July 6, 1967, *that I last saw the deceased alive on* July 6, 1967, *and that death occurred at* 6:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: ARCH WIGLE, M.D. (Degree or title): 566

23b. ADDRESS: 1605 North Arthur, Pocatello, Idaho

23c. DATE SIGNED: 7-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Jul. 12, 1967

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens

24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: 7-12-67

REGISTRAR'S SIGNATURE: Harry Keeley

25. EMBALMER: Conway Grant — LICENSE NO.: E476

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 23 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2875
Local Reg. No. 188
Reg. Dist. No. 510

RECEIVED
03/ JUL 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 155 Spence

3. NAME OF DECEASED (Type or Print): a. (First) RONALD; b. (Middle) CHARLES; c. (Last) DIAL

4. DATE OF DEATH (Month) (Day) (Year): July 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: Oct. 24, 1949

9. AGE (In years last birthday): 17 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: I.S.U.

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oliver Eugene Dial
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Betty Jean Wynkoop
BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): xxxx

16. SOCIAL SECURITY NO.: 546 70 0350

17. INFORMANT'S OWN SIGNATURE: [signature]
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 1731

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by monoxide gas(self Adm.)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide 2

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home garage 01

21c. (CITY, TOWN, OR TOWNSHIP): Pocatello 13 031 (COUNTY): Bannock (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 9, 1967 9:20 P.M. 2

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Self Administered

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Wayne L. Loveless 583 H (Degree or title): Acting Coroner

23b. ADDRESS: 351 Roosevelt Ave Pocatello

23c. DATE SIGNED: 11 July, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Jul. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: 7-12-67

REGISTRAR'S SIGNATURE: Sally Kellogg

25. EMBALMER: Conway Grant
LICENSE NO.: E478
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form UH-63021

DUTIES:

JUL 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2876
Local Reg. No. 191
Reg. Dist. No. 510

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031 1-34
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 34 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 1206 So. 4th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): JACK
b. (Middle): 018
c. (Last): HAMILTON

4. DATE OF DEATH (Month) (Day) (Year): July 11 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 22, 1907
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Butte, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Hamilton — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Burdette Coutts — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 565-03-1022
17. INFORMANT'S OWN SIGNATURE: Mrs Leah Hamilton — ADDRESS: Pocatello, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

157X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): ADENOCARCINOMA OF PANCREAS — INTERVAL BETWEEN ONSET AND DEATH: 7 MOS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: GENERALIZED CARCINOMATOSIS

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 FEB, 1967, *to* 11 JULY, 1967, *that I last saw the deceased alive on* 11 JULY, 1967, *and that death occurred at* 10:10A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. R. Hearne 220 W. R. HEARNE, MD
23b. ADDRESS: POCATELLO, IDAHO
23c. DATE SIGNED: 12 JULY 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 15 July 67
24c. NAME OF CEMETERY OR CREMATORY: Mountainview
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: 7-13-67
REGISTRAR'S SIGNATURE: Lacey Kellogg
25. EMBALMER: George W. Knoth
LICENSE NO.: 409

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 18 1967

JUL 21 1967

JUL 3 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to certify the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2877
Local Reg. No. 209
Reg. Dist. No. 511

RECEIVED AUG 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
c. LENGTH OF STAY (in this place): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lava Hot Springs 030

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	HENRY 020	ARMYON	July 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married S	April 13,1891	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
City of Lava and Railroad	10	Bucharest, Romania	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Armyon	Romania	Mary Lasco	Romania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX	518 05 9046	Mary A. Armyon	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Carcinoma of Stomach	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* July 12, 1967, *that I last saw the deceased alive on* __, 19__ *and that death occurred at* __ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Downey Id	7.17.67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jul.15,1967	Central Cemetery	Central, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 7 1967	Maureen Schulke, Deputy	Conway Grant	E478

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2878
Local Reg. No. 195
Reg. Dist. No. 510

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 840 No. Garfield

3. NAME OF DECEASED (Type or Print): a. (First) CLAIRE b. (Middle) H 018 c. (Last) STAFFORD

4. DATE OF DEATH: (Month) July (Day) 12 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Mar. 3, 1889

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer 10

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Auburn, Indiana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harrison Stafford
BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Florence Heberling
BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Mrs C. N. Stafford
ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4330

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Heart Block — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Cardiac decompensation — 5-7 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 July, 1967, *to* 12 July, 1967, *that I last saw the deceased alive on* 12 July, 1967 *and that death occurred at* 5 06 m., *from the causes and on the date stated above.*

23a. SIGNATURE 406 (Degree or title): Clark Dankenm MD

23b. ADDRESS: 3930 Lewis, Pocatello Ida

23c. DATE SIGNED: 13 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 17 July 1967

24c. NAME OF CEMETERY OR CREMATORY: Mount Moriah

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: 7-14-67

REGISTRAR'S SIGNATURE: Lucy Kellogg

25. EMBALMER: George W. Knoll
LICENSE NO.: 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2879
Local Reg. No. 176
Reg. Dist. No. 510

RECEIVED
Bureau of Vital Statistics
JUL 21 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
DURATION OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 325 South 9th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): HENRY 019
c. (Last): COOPER

4. DATE OF DEATH: (Month) July (Day) 13, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 16, 1895
9. AGE (In years last birthday): 71
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Brakemen 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Cooperstown, Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph M. Cooper
BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Lillie May Dunmire
BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Mrs Dollie H Cooper 325 S 9th

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 Hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease — Yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Congestive Heart Failure 2 Wks.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello Bannock Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-VII, 1967, *to* 13-VII, 1967, *that I last saw the deceased alive on* 13-VII, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 465 M.J.Sharp,M.D.
23b. ADDRESS: 5th & Center, Pocatello, Idaho
23c. DATE SIGNED: 7/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jul. 17, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: 7-19-67
REGISTRAR'S SIGNATURE: Lucy Ludwig
25. EMBALMER: Conway Grant
LICENSE NO.: E478
FIRM NAME: Fanning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2880
Local Reg. No. 200
Reg. Dist. No. 511

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall 030
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): LUCILLE
b. (Middle):
c. (Last): WHEELER

4. DATE OF DEATH (Month) (Day) (Year): July 16, 1967

5. SEX: Female
6. COLOR OR RACE: Indian 3
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 17, 1940
9. AGE (In years last birthday): 26 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Fort Hall, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Frank Quagigant
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Ida Pahneeno — Fort Hall, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Lillian Quagigant

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5811

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Ciarhosis and fatty metamorphosis of liver

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Chemical Hepatitis
DUE TO (c): Alcohol

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on* July 16, 1967, *and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 069 Calvin Buhler MD
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jul. 19, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sand Hill Cemetery
24d. LOCATION (City, town, or county) (State): Fort Hall, Idaho

DATE REC'D BY LOCAL REG.: AUG 1 1967
REGISTRAR'S SIGNATURE: Maureen Schelske, Deputy
25. EMBALMER: F. B. Oakley
LICENSE NO.: E418

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2881
Local Reg. No. 199
Reg. Dist. No. 510

RECEIVED Bureau of Vital Statistics JUL 27 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (In this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Mercy Hosp..

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 205 No. 13th Ave.

3. NAME OF DECEASED (Type or Print): a. (First) OLIVER b. (Middle) PIERCE 019 c. (Last) SCARBOROUGH

4. DATE OF DEATH: (Month) July (Day) 17 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Jan. 3, 1885
9. AGE (In years last birthday): 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman 10
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Kingston, Tennessee
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Scarborough BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Eliza Bullen BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 712-03-9118
17. INFORMANT'S OWN SIGNATURE: Clyde Scarborough ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — Yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4201

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-9, 1967, *to* 7-17, 1967, *that I last saw the deceased alive on* 7-16, 1967, *and that death occurred at* 5 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: 356 R. L. Merrell (Degree or title) M.D.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 20 Jul 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gdns.
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: 7-21-67
REGISTRAR'S SIGNATURE: Lacy Kellogg
25. EMBALMER: George W. Knapp
LICENSE NO.: 409

FIRM NAME: Downard Funeral Home.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2882
Local Reg. No. 210
Reg. Dist. No. 511

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey
c. STREET OR R.F.D. NO. (If rural, give location) 008
d. FULL NAME OF HOSPITAL OR INSTITUTION Marsh Valley Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lava Hot Springs 030
d. STREET ADDRESS (If rural, give location) P.O. Box 681

3. NAME OF DECEASED (Type or Print)
a. (First) ALLEN
b. (Middle) C. 020
c. (Last) STRACHAN

4. DATE OF DEATH (Month) (Day) (Year) July 18, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 21, 1887
9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10
10b. KIND OF BUSINESS OR INDUSTRY U.P.R.R.
11. BIRTHPLACE (State or foreign country) Soda Springs, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Strachan BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME Ruth Atkinson BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) XXXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE C. Strachan ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____ 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Carl Rambo 070 (Degree or title)
23b. ADDRESS Downey Id
23c. DATE SIGNED 8.14.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Jul. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery
24d. LOCATION (City, town, or county) (State) Soda Springs, Caribou, Idaho

DATE REC'D BY LOCAL REG. AUG 7 1967
REGISTRAR'S SIGNATURE Maureen Schibsky, Deputy
25. EMBALMER Conway Grant LICENSE NO. E478
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 8 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2883
Local Reg. No. 201
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 226 Fairbanks Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): HAMP 019
c. (Last): THORNLEY

4. DATE OF DEATH (Month) (Day) (Year): July 18 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 29, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Locomotive Engineer 10
10b. KIND OF BUSINESS OR INDUSTRY: Union Pacific R. R.
11. BIRTHPLACE (State or foreign country): Smithfield, Utah
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: John Thornley, BIRTHPLACE: Smithfield, Utah
14. MOTHER'S MAIDEN NAME: Lydia H. Baker, BIRTHPLACE: Raunds, England
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 712-05-3289
17. INFORMANT'S OWN SIGNATURE: Mrs Robt H Thornley — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH 5271
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cor Pulmonale — yrs —
DUE TO (c): Chronic Pulmonary emphysema, Bronchitis & asthma — yrs —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to* July 18, 19 67, *that I last saw the deceased alive on* July 18, 19 67, *and that death occurred at* 9:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 362 [signature], M.D.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: July 20, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: 7-31-67
REGISTRAR'S SIGNATURE: Maureen Schelske, Deputy
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2884
Local Reg. No. 202
Reg. Dist. No. 510

BIRTH NO.

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 570 South 19th Avenue

3. NAME OF DECEASED (Type or Print): a. (First) THOMAS b. (Middle) STACY 018 c. (Last) SMITH

4. DATE OF DEATH: (Month) July (Day) 19 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 24, 1910

9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant 22

10b. KIND OF BUSINESS OR INDUSTRY: Retail Store

11. BIRTHPLACE (State or foreign country): Pocatello Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Samuel P. Smith

14. MOTHER'S MAIDEN NAME: Ella Stacy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War II 4

16. SOCIAL SECURITY NO.: 519-09-8599

17. INFORMANT'S OWN SIGNATURE: Rosie P. Smith — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral lung contusion and pneumothorax and cardiac contusion.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe crushing injury of chest
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 7-17-67

19b. MAJOR FINDINGS OF OPERATION: As above.

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident /

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Fishing 00

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 030 Bannock **(STATE)** Idaho

21d. TIME OF INJURY: (Month) 5 (Day) 16 (Year) 67 (Hour) 9.30 p. m.

21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?: Struck by bed of wrecker truck

22. *I hereby certify that I attended the deceased from* July 17, *19* 67, *to* July 19, *19* 67, *that I last saw the deceased alive on* July 19, *19* 67 *and that death occurred at* 3:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 187 Wm Graves, M.D.

23b. ADDRESS: Pocatello, Idaho

23c. DATE SIGNED: July 21, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 21, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: 7-28-67

REGISTRAR'S SIGNATURE: Maureen Ickelsen, Deputy

25. EMBALMER: Jack Henderson — **LICENSE NO.**: E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 9 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 17 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2885
Local Reg. No. 199
Reg. Dist. No. 511

BIRTH NO.

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Los Angeles
d. STREET ADDRESS (If rural, give location) 114 8½ West Florence

3. NAME OF DECEASED (Type or Print) a. (First) MATILDA b. (Middle) ANN c. (Last) STEGELMEIER MOYER

4. DATE OF DEATH (Month) (Day) (Year) June 20, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 14 May 1906
9. AGE (In years last birthday) 61 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secy-Typist 19
10b. KIND OF BUSINESS OR INDUSTRY Business
11. BIRTHPLACE (State or foreign country) Greentimber, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Otto Stegelmeier BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Dora Hargins BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----------
16. SOCIAL SECURITY NO. 550-34-2886
17. INFORMANT'S OWN SIGNATURE Family Records ADDRESS Robert Bean Funeral Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Colon with Hemorrhage 1538

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastasis to abdomen & Chest
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: approx 15 months

19a. DATE OF OPERATION 1966
19b. MAJOR FINDINGS OF OPERATION Carcinoma of Colon
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* May, 1967, to 6-20, 1967, *that I last saw the deceased alive on* 6-20, 1967, *and that death occurred at* 11:55 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE 362 Dennis E. Miller M.D. (Degree or title)
23b. ADDRESS Pocatello, Idaho
23c. DATE SIGNED 7-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 23 June 1967
24c. NAME OF CEMETERY OR CREMATORY Pineview Cemetery
24d. LOCATION (City, town, or county) (State) Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG. JUL 31 1967
REGISTRAR'S SIGNATURE Maureen Schelske, Deputy
25. EMBALMER Robert A. Bean
LICENSE NO. E-456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bean Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 16 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 17 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2886
Local Reg. No. 277
Reg. Dist. No. 511

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 030 AUG 16 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Marsh Valley Hospital 020

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCammon 030
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) CARL
b. (Middle) BERNARD
c. (Last) ANDERSON

4. DATE OF DEATH (Month) (Day) (Year) July 20, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 0
8. DATE OF BIRTH April 19, 1887
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hans Anderson — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Anna Hansen — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) XXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Joseph C Anderson — ADDRESS

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerose
DUE TO (c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1964, 19__, *to* 1967, 19__, *that I last saw the deceased alive on* July 20, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Carol Burhett M.D. 070 (Degree or title)
23b. ADDRESS Downey Id
23c. DATE SIGNED 8 4 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Jul. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY Lund Cemetery
24d. LOCATION (City, town, or county) (State) Lund, Caribou, Idaho

DATE REC'D BY LOCAL REG. AUG 7 1967
REGISTRAR'S SIGNATURE Maureen Schelsky Deputy
25. EMBALMER Conway Grant
LICENSE NO. E478
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 17 1967

APR 16 1982

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2887
Local Reg. No. 209
Reg. Dist. No. 511

BIRTH NO.

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA St. Anthony Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Kentucky
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Louisville
d. STREET ADDRESS (If rural, give location): 7701 Kim Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WILLARD	F. 000	DAVIS	July 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	Feb. 11, 1923	44				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welder 21	Welding	Richardsville, Ky.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Davis			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Delbert H Edstrom	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cc Coronary Thrombosis 4201 — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R C Brett 583 Acting Coroner 4	836 E. Center, Pocatello, Idaho 836 E. Center Pocatello Idaho	7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Jul. 21, 1967	Nunnelley Funeral Home, Louisville, Kentucky	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 1 1967	Maureen Schelske Deputy	Conway Grant	E 476

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2888
Local Reg. No. 205
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 133 Taft

3. NAME OF DECEASED (Type or Print)
a. (First): LUCILLA
b. (Middle): E. 018
c. (Last): HANCOCK

4. DATE OF DEATH (Month) (Day) (Year): July 20, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Jan. 2, 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Franklin, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Benjamin Charles Baker — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Lucy Evans — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Sanley J. Hancock — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardio Vascular Disease with cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: yes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes Mellitus — yes

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 7-20-, 1967, *that I last saw the deceased alive on* 7-20, 1967, *and that death occurred at* 8 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: D Miller, Jr. D. 362 (Degree or title)
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 7-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jul. 24, 1967
24c. NAME OF CEMETERY OR CREMATORY: Franklin Cemetery
24d. LOCATION (City, town, or county) (State): Franklin, Idaho

DATE REC'D BY LOCAL REG.: 7-28-67
REGISTRAR'S SIGNATURE: Maureen Schelske, Deputy
25. EMBALMER: Conway Grant — LICENSE NO. E478
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2889
Local Reg. No. 206
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): Bannock Memorial Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): ROGERS 018
c. (Last): JARVIS

4. DATE OF DEATH (Month) July (Day) 21 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 15, 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: *****
11. BIRTHPLACE (State or foreign country): Challis, Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Joseph H. Rogers — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Mary (no data) — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: *****
17. INFORMANT'S OWN SIGNATURE: Richard C. Jarvis — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Ht. Dis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Gastric Ulcer — 2 yr

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, *19*___, *to* July 21, *19*67, *that I last saw the deceased alive on* July 3, *19*67, *and that death occurred at* 7:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE: 248 R. Howell (Degree or title)
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: July 24, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 24, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: JUL 31 1967
REGISTRAR'S SIGNATURE: Maureen Schelske, Deputy
25. EMBALMER: Just Henderson
LICENSE NO.: E-349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 16 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2890
Local Reg. No. 212
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lava Hot Springs 030
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEONARD	JOHN	WARE	July 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Aug. 11, 1910	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 21	Garage	Downey, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel Ware	Downey, Idaho	Edith Dianna Bloxham	Downey, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXXX		Dean Ware	Lava Hot Springs, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Congestive Heart Failure	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Emphysema - Asthma	
DUE TO (c)	Cor Pulmonale	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1957, 19___, *to* July 22 67, 19___, *that I last saw the deceased alive on* July 21, 1967, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Downey Id	8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jul. 25, 1967	Lava Hot Springs Cem.	Lava Hot Springs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 7 1967	[signature] Deputy	[signature]	E478

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2891
Local Reg. No. 207
Reg. Dist. No. 510

BIRTH NO.

RECEIVED 031 AUG 7 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 232 South 9th Avenue

3. NAME OF DECEASED (Type or Print): a. (First) JANE b. (Middle) 018 c. (Last) FOREMAN

4. DATE OF DEATH (Month) (Day) (Year): July 24, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: June 29, 1891

9. AGE (In years last birthday): 76 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Spanish Fork, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Howells — BIRTHPLACE: Wales

14. MOTHER'S MAIDEN NAME: Mary Jane Boyack, Spanish Fork, Utah — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): xxxx

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: William E Foreman Jr — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

42201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction, mild — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute congestive heart failure — Hours
DUE TO (c) Anuria — Hours

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Advanced age — Years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): None

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 2-7- , 1961, *to* 7-24- , 1967, *that I last saw the deceased alive on* 7-24- , 1967, *and that death occurred at* 9:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 566 (Degree or title): Arch Wigle, M.D. — **23b. ADDRESS**: 1605 N. Arthur, Pocatello, Ida — **23c. DATE SIGNED**: 7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: July 28, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Mountainview Cemetery — **24d. LOCATION** (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REGISTRAR: AUG 1 1967 — **REGISTRAR'S SIGNATURE**: Maureen Schalske Deputy — **25. EMBALMER**: Conway Grant — **LICENSE NO.**: E426 — **FIRM NAME:**

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 8 1967

JAN 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2892
Local Reg. No. 214
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 1125 North Garfield

3. NAME OF DECEASED (Type or Print): a. (First) PARLEY b. (Middle) c. (Last) HEMMING

4. DATE OF DEATH (Month) (Day) (Year): July 26, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 10, 1895

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist 10

10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.

11. BIRTHPLACE (State or foreign country): Morgan, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred John Hemming
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Adelgunda
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 24, 1967, *to* July 26, 1967, *that I last saw the deceased alive on* July 26, 1967, *and that death occurred at* 2:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Richard E. Butler 400 (Degree or title) M.D.

23b. ADDRESS: 246 N. 18th

23c. DATE SIGNED: 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Jul. 29, 1967

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens

24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: AUG 7 1967

REGISTRAR'S SIGNATURE: Maureen Schelske Deputy

25. EMBALMER: Conway Grant

LICENSE NO.: E478

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 17 1967

SEP 5 1967

SEP 7 1967

NOV 8 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED.
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended 8-22-67

Certificate of Death

STATE OF IDAHO

State File No. 2893
Local Reg. No. 208
Reg. Dist. No. 510

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hosp. 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 623 So. Sixth Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Rolly b. (Middle) Walter c. (Last) Thompson

4. DATE OF DEATH: (Month) July (Day) 26, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 20, 1913

9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant 19

10b. KIND OF BUSINESS OR INDUSTRY: Accounting

11. BIRTHPLACE (State or foreign country): Utica, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W. Thompson — BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Vera A. Copping — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-09-9503

17. INFORMANT'S OWN SIGNATURE: Mrs. R. W. Thompson — ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): acute anter o-septal myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-5-60, 19 60, *to* July 26, 19 67, *that I last saw the deceased alive on* July 26, 1967, *and that death occurred at* 2:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: John E. Comstock — (Degree or title): M.D. 101

23b. ADDRESS: P.O. Box 852

23c. DATE SIGNED: 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 26 July 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: 8-2-67

REGISTRAR'S SIGNATURE: Maureen Schelska, Deputy

25. EMBALMER: George W. Knoff — LICENSE NO.: 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

State of Idaho } ss.
County of Bannock }

Certificate No. .....

Date Filed Aug. 7, 1967

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Rolly Walter Thompson (Name on Original Certificate) who died (Was Born or Died) on July 26, 1967 (Date of Event)
in Pocatello (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Mortuary Records (Bible Record, Insurance Policy, Etc.) prepared on July 26, 1967 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Birth Date	Dec. 20, 1967	Dec. 20, 1913

Subscribed and sworn to before me this 19th day of August, 19 67

John P. Thomas

Notary Public, residing at Pocatello, Idaho
My commission expires June 20, 1968
(Seal)

Signed Byron B. Dunnard
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

241 N. Garfield, Pocatello, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Bannock }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 19th day of August, 19 67

John P. Thomas

Notary Public, residing at Pocatello, Idaho
My commission expires June 20, 1968
(Seal)

Signed Mina M. Dunnard
(Signature of Any Credible Person)

241 N. Garfield, Pocatello, Idaho
(Street Address, City, State)

STATE OF IDAHO

DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho ss. Certificate No.

County of Bannock Date Filed Aug. 7, 1967

RECEIVED AUG 21 1967 Bureau of Vital Statistics

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)

for Rolly Walter Thompson (Name on Original Certificate) who died (Was Born or Died) on July 26, 1967 (Date of Event)

in Pocatello (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the

true facts are shown by Mortuary Records (Bible Record, Insurance Policy, Etc.) prepared on July 26, 1967 (Give Date) are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Birth Date	Dec. 20, 1967	Dec. 20, 1915

Subscribed and sworn to before me this 19th day of August 1967

Signed [signature] (Signature of parent or attendant if correcting a birth record; of attendant, funeral director, or armed if correcting a death record; or other credible person.)

Notary Public, residing at Pocatello, Idaho

My commission expires June 20, 1968 241 N. Garfield, Pocatello, Idaho (Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

This Affidavit MUST also be Recorded. (See Chapter 138, 1957 Idaho Session Laws.)

State of Idaho ss.

County of Bannock

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 19th day of August 1967

Signed [signature] (Signature of Any Credible Person)

Notary Public, residing at Pocatello, Idaho

My commission expires June 20, 1968 241 N. Garfield, Pocatello, Idaho (Street Address, City, State)

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 208
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 623 So. Sixth Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	ROLLY	WALTER	THOMPSON	July	26	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 20, 1967	55				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Accountant	Accounting	Utica, Kansas	usa

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John W. Thompson	Kansas	Vera A. Copping	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-09-9503	Mrs. R.W. Thompson	Pocatello

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute anter o-septal myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-5-60, 1960, *to* July 26, 1967, *that I last saw the deceased alive on* July 26, 1967, *and that death occurred at* 2:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John L. Comstock M.D.	P. O. Box 852	7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	26 Jul 1967	Mountainview	Pocatello	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-3-67	Maureen Schaleka, Deputy	George W. Knoll	409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 17 1967

AUG 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2894
Local Reg. No. 213
Reg. Dist. No. 510

Certificate of Death

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 3830 Nora

3. NAME OF DECEASED (Type or Print)
a. (First): ARTHUR
b. (Middle): LEWIS
c. (Last): WATSON

4. DATE OF DEATH (Month) (Day) (Year): July 26, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married/
8. DATE OF BIRTH: Feb.15, 1898
9. AGE (In years last birthday): 69 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Service and
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R. 10
11. BIRTHPLACE (State or foreign country): Logan, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur Watson — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Gertrude Elizabeth — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes World War I & II
16. SOCIAL SECURITY NO.: 712 05 1478
17. INFORMANT'S OWN SIGNATURE: Eugene A Watson — ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

43304

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — *, 19*__*, to* — *, 19*__*, that I* ~~last~~ *saw the deceased* death *on* 7-26-, 1967, *and that death occurred at* 8 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Burton S John 583 4 (Degree or title) Coroner
23b. ADDRESS: Bannock Co. Idaho
23c. DATE SIGNED: 8-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jul.29,1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: AUG 15 1967
REGISTRAR'S SIGNATURE: Maureen Schelske, Deputy
25. EMBALMER: Conway Grant
LICENSE NO.: E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2895
Local Reg. No. 215
Reg. Dist. No. 511

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rockland 390
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLES
b. (Middle): HARRESON 294
c. (Last): DONNELLY

4. DATE OF DEATH (Month) (Day) (Year): July 26, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 16, 1877
9. AGE (In years last birthday): 90
IF UNDER 1 YEAR: Months 3 Days 10
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Mountain City, Tenn.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richard H. Donnelly
BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Eliza Moore
BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-44-2298
17. INFORMANT'S OWN SIGNATURE: George M Donnelly
ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arterio sclerotic cardio — Vascular Disease
INTERVAL BETWEEN ONSET AND DEATH: yes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May - 67, 19__, *to* 7-26, 1967, *that I last saw the deceased alive on* 7-19-, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 362 Daniel E. Miller, MD
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Burial 3
24b. DATE: 7-29-67
24c. NAME OF CEMETERY OR CREMATORY: Valley View Cemetery
24d. LOCATION (City, town, or county) (State): Rockland, Idaho

DATE REC'D BY LOCAL REG.: 8-4-67
REGISTRAR'S SIGNATURE: Maureen Schelske, Deputy
25. EMBALMER: Bud Kelly Bud Kelly
LICENSE NO.: E-467

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2896
Local Reg. No. 216
Reg. Dist. No. 510

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 1 6 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031 404
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Comm. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 751 McKinley

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): T 019
c. (Last): CONNELL

4. DATE OF DEATH (Month) (Day) (Year): July 29 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 30, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber 21
10b. KIND OF BUSINESS OR INDUSTRY: Plumbing
11. BIRTHPLACE (State or foreign country): Selma, Alabama
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John T. Connell — BIRTHPLACE: Ireland
14. MOTHER'S MAIDEN NAME: Mary M. Hargrone — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 556-03-1716
17. INFORMANT'S OWN SIGNATURE: Ruth Kingston — ADDRESS: 4295 So 175 West Ogden

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease & coronary sclerosis — INTERVAL BETWEEN ONSET AND DEATH: yes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960 —, 19__, *to* 7-29 —, 1967, *that I last saw the deceased, alive on* 7-29 —, 1967, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 362 D. Miller, JMD
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: 8-2-67
REGISTRAR'S SIGNATURE: Maureen Schelske, Deputy
25. EMBALMER: George W. Knopp
LICENSE NO.: 409

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downa rd Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 21 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-7296

BIRTH NO.

RECEIVED AUG 16 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2897
Local Reg. No. 217
Reg. Dist. No. 510

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 1154 North Yellowstone

3. NAME OF DECEASED (Type or Print)
a. (First): SHAWN
b. (Middle): 018
c. (Last): ROBERTS

4. DATE OF DEATH (Month) (Day) (Year): July 30, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: July 27, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days: 3; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: XXXX
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Marvin Daryl Roberts
BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Vickie Warth
BIRTHPLACE: Pocatello, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: XXXX
17. INFORMANT'S OWN SIGNATURE: Marvin D. Roberts
ADDRESS: 1154 No. Yellowst

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7545

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congenital heart disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): (hypoplastic left heart)
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-28, 1967, *to* 7-30, 1967, *that I last saw the deceased alive on* 7-30, 1967, *and that death occurred at* 7:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): D B Roberts 737 M.D.
23b. ADDRESS: 527 So 12th Ave, Pocatello
23c. DATE SIGNED: 4 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY: Malad Cemetery
24d. LOCATION (City, town, or county) (State): Malad, Oneida, Idaho

DATE REC'D BY LOCAL REG.: AUG 8 1967
REGISTRAR'S SIGNATURE: Maureen Schelske, Deputy
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Manning Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2898
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

JUL 18 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: Montpelier Idaho
c. LENGTH OF STAY: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bear Lake Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bear Lake 040
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: Paris Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First): Loos
b. (Middle): Ann 024
c. (Last): Wallentine

4. DATE OF DEATH (Month) (Day) (Year): July 1 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 3 1931
9. AGE (In years last birthday): 36
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): St. Charles Idaho
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Alvin Peterson — BIRTHPLACE: St. Charles Ida
14. MOTHER'S MAIDEN NAME: Bertha Ann Benson — BIRTHPLACE: St. Charles Ida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-54-4727
17. INFORMANT'S OWN SIGNATURE: Lloyd C. Wallentine — ADDRESS: Paris Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

174 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): metastatic carcinoma of the uterus

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 9 mos

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Montpelier Bear Lake Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* 1 July, 1967, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 458 [signature] MD
23b. ADDRESS: Montpelier Idaho
23c. DATE SIGNED: 7-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 5 1967
24c. NAME OF CEMETERY OR CREMATORY: Paris Cemetery
24d. LOCATION (City, town, or county) (State): Paris Idaho

DATE REC'D BY LOCAL REG.: 7-14-67
REGISTRAR'S SIGNATURE: Mrs Ruby Gortcinski
25. EMBALMER: Nile Matthews
LICENSE NO.: E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 2899
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake 040 AUG 8 - 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Burial Vital Statistics) Montpelier
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. STREET ADDRESS (If rural, give location) 822 Jefferson

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) John 024 c. (Last) Ansell

4. DATE OF DEATH (Month) (Day) (Year) July 18, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 18, 1895
9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Conductor
10b. KIND OF BUSINESS OR INDUSTRY U. P. Rail Road
11. BIRTHPLACE (State or foreign country) London, England
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Rueben Ansell 10 BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Hannah Jane Jones BIRTHPLACE Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO. 712-05-1536
17. INFORMANT'S OWN SIGNATURE Hope Ansell ADDRESS Montpelier Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — 10 yrs
DUE TO (c) diabetes mellitus — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Montpelier Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1961, *to* 18 July, 1967 *that I last saw the deceased alive on* 18 July, 1967, *and that death occurred at* 12 *m., from the causes and on the date stated above.*

23a. SIGNATURE 458 [signature] (Degree or title)
23b. ADDRESS Medicine Montpelier Idaho
23c. DATE SIGNED 7-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 22 1967
24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery
24d. LOCATION (City, town, or county) (State) Montpelier Idaho

DATE REC'D BY LOCAL REG. 7-29-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinsky
25. FUNERAL DIRECTOR Nile Matthews ADDRESS E359 Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES: AUG 9 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

State File No. 2900
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier Idaho
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bear Lake Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salt Lake City 21 555
d. STREET ADDRESS (If rural, give location): 3091 East 7180 South

3. NAME OF DECEASED (Type or Print)
a. (First): DOUGLAS
b. (Middle): GLENN 024
c. (Last): RIDD

4. DATE OF DEATH (Month) (Day) (Year): July 22, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 28, 1931
9. AGE (In years last birthday): 36 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpet Layer 30
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): Murray, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Glenn Chase Ridd — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Irene Hill — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yess — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Joan B. Ridd — ADDRESS: 3091 East 7180 South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: July 22 1967
19b. MAJOR FINDINGS OF OPERATION: Physical Examination
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22, 1967, *to* July 22, 1967, *that I last saw the deceased alive on* July 22, 1967, *and that death occurred at* 7:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Allen Rich 439 (Degree or title) MD
23b. ADDRESS: Montpelier Idaho
23c. DATE SIGNED: 7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Elysian Burial Gardens
24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: 7-28-67
REGISTRAR'S SIGNATURE: Mrs Ruby Gortcinski
25. EMBALMER: Nile Matthews
LICENSE NO.: E359

Federal Security Agency
United States Public Health Service
Form DH-6[illegible]021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 10 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 30 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

State File No. 2901
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
c. LENGTH OF STAY (in this place) 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 45 Utah
b. COUNTY 553 Davis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bountiful
d. STREET ADDRESS (If rural, give location) 416 East Spring Creek Dr.

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) Robert c. (Last) Campbell

4. DATE OF DEATH (Month) (Day) (Year) July 23 1967

5. SEX M.
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 7, 1922
9. AGE (In years last birthday) 45 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Furrier 21
10b. KIND OF BUSINESS OR INDUSTRY J.C.M.I.
11. BIRTHPLACE (State or foreign country) Salt Lake City Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Campbell BIRTHPLACE Salt Lake City Ut.
14. MOTHER'S MAIDEN NAME Louise Schuman BIRTHPLACE Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or date of service) World War II 4387
16. SOCIAL SECURITY NO. 529-16-8349
17. INFORMANT'S OWN SIGNATURE Vyrna H. Campbell ADDRESS Bountiful Ut.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH 30 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23, 1967 *to* 7-23, 1967, *that I last saw the deceased alive on* 7-23, 1967, *and that death occurred at* 5:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE Paul [illegible] (Degree or title) 126 M.D.
23b. ADDRESS Montpelier Ida
23c. DATE SIGNED 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE July 27, 1967
24c. NAME OF CEMETERY OR CREMATORY Bountiful M. Park
24d. LOCATION (City, town, or county) Bountiful (State) Utah

DATE REC'D BY LOCAL REG. 7-26-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinsky
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 26 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUN 21 1982

PENALTIES: Under the Idaho law, it is a misdemeanor to

MAR 28 1986

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2902
Local Reg. No.
Reg. Dist. No. 552

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 029 Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Montpelier Rural
LENGTH OF STAY (in this place): 14 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 040 Bear Lake
CITY OR TOWN (If outside corporate limits, write RURAL, and give township): Dingle Idaho
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	Cyril	L. 024	Dayton

4. DATE OF DEATH: (Month) July (Day) 29 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Jan. 25, 1901	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04		Dingle Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Theodore Dayton	Cedar Fort Ut	Lucy Ann Nate	Paris Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-07-4395	Mrs. Myrtle Dayton	Dingle Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia Terminal Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senile Degeneration — 3 weeks

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
July 27 1967	Surgical Expose L.K. Christ Logan	YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, to July 29, 1967, *that I last saw the deceased alive on* July 29, 1967, *and that death occurred at* 1150 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
439 (Degree or title)	Montpelier Idaho	8-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 1 1967	Dingle Cemetery	Dingle Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-2-67	Mrs Ruby Golcinsky	Nile Matthews	E359

Federal Security Agency
United States Public Health Service
Form DH-6021

FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 20 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2903
Local Reg. No. 17
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 030 Benewah 201
b. CITY OR TOWN St. Maries
LENGTH OF STAY (in this place) 3 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Community Hospital 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 030 Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
d. STREET ADDRESS (If rural, give location) 138 N. 8th St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Marie	M.	Ajdukovic	April	20,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
female	white	widowed 2	March 14, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	domestic	Minnesota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Warzea	Poland	Mary Colling	France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (G.B.)	ADDRESS
no	none	518-54-0181	George Kovich	1931 Heron St., Klamith Falls, Oreg

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiac decompensation

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Mar., 1967, *to* Apr. 20, 1967, *that I last saw the deceased alive on* Apr. 20, 1967, *and that death occurred at* 8:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. A. Rapp 428 M.D.	St. Maries, Idaho	5-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	4-24-67	Woodlawn Cemetery	St. Maries Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
5-3-67	Wanda Simics	Gerald Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 24 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 7 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

67-3237

BIRTH NO.

Certificate of Death

RECEIVED STATE OF IDAHO

JUL 27 1967

Bureau of Vital Statistics

State File No. 2904
Local Reg. No. 15
Reg. Dist. No. 130

1. PLACE OF DEATH

a. COUNTY 050 Benewah — 505

b. CITY OR TOWN St. Maries

c. LENGTH OF STAY IN (this place) few min.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Community Hospital — 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho — 050

b. COUNTY Benewah

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries

d. STREET ADDRESS (If rural, give location) Rt. #2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Brian	James	Fly	April	28,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	never married	April 28, 1967					few

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none 02	none	Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James W. Fly	Montana	Marylu Belle Jennings	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS (G.B)
no	none	none	James W. Fly	Rt. #2, St. Maries, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7620

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary atelectosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-28, 1967, *to* 4-28, 1967, *that I last saw the deceased alive on* 4-28, 1967, *and that death occurred at* 7:34 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bruce E Rakuck 427 MD	St. Maries, Idaho	5-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	May 1, 1967	Woodlawn Cemetery	St. Maries Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Wanda Simms	Gerald E. Browning	E-411

FIRM NAME: Browning Funeral Home

Form DH-63021

Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be completed as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

D: 67-3237

Certificate of Death

STATE OF IDAHO

State File No. 2905
Local Reg. No. 16
Reg. Dist. No. 130

BIRTH NO.

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 850 Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY IN THIS PLACE DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Community Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280 b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Worley (rural)
d. STREET ADDRESS (If rural, give location) Rt. # 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Jess	W.	Wright	May	1,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	11-3-1915	51				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04	wheat-peas	Linneus, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harry Wright	Linneus, Missouri	Edith Kennedy	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	W.W.II 4	518-12-4775	Mrs. Jess Wright	Worley, Idaho (M.L.S)

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4207

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 80 mins.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* DOA, 19____, *to* 5-1, 1967, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 6:20P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. A. Thurston	533 MD	St. Maries, Idaho	5-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	5-4-67	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
5-4-67	Wanda Dennis	M. L. Schanzenbach	

FIRM NAME: Schanzenbach Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

JUL 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 9 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 27 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2906
Local Reg. No. 28
Reg. Dist. No. 130

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 050 Benewah 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural (Tensed)
c. LENGTH OF STAY (in this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 Old Tekoa-Tensed Highway

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 050
b. COUNTY Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Tensed
d. STREET ADDRESS (If rural, give location) General Delivery

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) ---
c. (Last) Ignace

4. DATE OF DEATH (Month) July (Day) 5 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 11, 1921
9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Diversified
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Ignace — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Lizette Vincent — BIRTHPLACE: Tensed, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W.W. II 4
16. SOCIAL SECURITY NO. 518-20-9388
17. INFORMANT'S OWN SIGNATURE: x Raymond J. Ignace — ADDRESS: Plummer Ida

8124

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive intra-abdominal

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) hemorrhage due to
DUE TO (c) a ruptured liver

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Tensed, Idaho 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Tensed 63 Benewah 050 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-5-67 12:30 A.m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Car-pedestrian accident

22. *I hereby certify that I attended the deceased from* DOA 2, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 12:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: B. A. Rapp 428 M.D. (Degree or title)
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sacred Heart Mission
24d. LOCATION (City, town, or county) (State): DeSmet Idaho

DATE REC'D BY LOCAL REG.: 8-10-67
REGISTRAR'S SIGNATURE: Wanda Dimico
25. EMBALMER: David O. Hansen
LICENSE NO.: E-510

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2907
Local Reg. No. 26
Reg. Dist. No. 130

BIRTH NO.

AUG - 1 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 050 Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (in this place) 13 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 050 Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
d. STREET ADDRESS (If rural, give location) 2045 Idaho Street

3. NAME OF DECEASED (Type or Print) a. (First) Elisha b. (Middle) Bell c. (Last) Siler

4. DATE OF DEATH (Month) July (Day) 7, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH July 30, 1882

9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04

10b. KIND OF BUSINESS OR INDUSTRY Diversified

11. BIRTHPLACE (State or foreign country) Kentucky

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME James Madison Siler BIRTHPLACE Kentucky

14. MOTHER'S MAIDEN NAME Anna Petre BIRTHPLACE Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 519-40-9973

17. INFORMANT'S OWN SIGNATURE Clara Bowman ADDRESS Latah, Washington

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

332X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-4 *1967, to* 4-7 *, 1967, that I last saw the deceased alive on* 4-7 *, 1967, and that death occurred at* 7:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE B. A. Rapp (Degree or title) M. D. 428

23b. ADDRESS St. Maries Idaho

23c. DATE SIGNED 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/10/1967

24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery

24d. LOCATION (City, town, or county) St. Maries (State) Idaho

DATE REC'D BY LOCAL REG. 7-26-67

REGISTRAR'S SIGNATURE Wanda Simms

25. EMBALMER David O. Hansen

LICENSE NO. E-510

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2908
Local Reg. No. 25
Reg. Dist. No. 130

BIRTH NO.

AUG - 1 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 050 Benewah 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Plummer
c. LENGTH OF STAY (in this place): few days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Near Milwaukee Depot 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 27 Montana
b. COUNTY: 555 Unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Unknown
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)
a. (First): Nathan
b. (Middle): W.
c. (Last): Buchanan

4. DATE OF DEATH (Month) (Day) (Year): July 13 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Unknown 0
8. DATE OF BIRTH: About 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Various
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?: Unknown

13. FATHER'S NAME: Unknown — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unknown — (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: 535-22-7331
17. INFORMANT'S OWN SIGNATURE: Gerald Browning — Information on deceased — ADDRESS: St. Maries

4281

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — Unknown

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19__, *to* _____, 19__, *that I last saw the deceased alive on* 7-13, 1967, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. D. Thurston 533 (Degree or title) MD
23b. ADDRESS: St Maries Idaho
23c. DATE SIGNED: 7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: 7-25-67
REGISTRAR'S SIGNATURE: Wanda Dimiss
25. EMBALMER: Gerald E Browning
LICENSE NO.: E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

OCT 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 29 1999

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics
AUG - 1 1967

Certificate of Death

STATE OF IDAHO

State File No. 2909
Local Reg. No. 27
Reg. Dist. No. 130

BIRTH NO. 67-6323

1. PLACE OF DEATH
a. COUNTY 030 Benewah
b. CITY OR TOWN St. Maries
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Benewah Comm. Hosp.
e. STREET ADDRESS (If rural, give location) —

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 030 Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fernwood

3. NAME OF DECEASED (Type or Print)
a. (First) Francesca
b. (Middle) Nicole
c. (Last) Shawver

4. DATE OF DEATH (Month) (Day) (Year) July 23 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH July 21, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days 2 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Rod Shawver — BIRTHPLACE Montana

14. MOTHER'S MAIDEN NAME Micheke Newbeck — BIRTHPLACE France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Rod Shawver — ADDRESS Fernwood, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Respiratory Distress Syndrome — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity — 7 day
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21, 1967, *to* 7-23, 1967, *that I last saw the deceased alive on* 7-23, 1967, *and that death occurred at* 6:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Bruce E. Rabuck (Degree or title) MD

23b. ADDRESS St Maries, Idaho

23c. DATE SIGNED 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 25, 1967

24c. NAME OF CEMETERY OR CREMATORY Woodlawn

24d. LOCATION (City, town, or county) (State) St. Maries Idaho

DATE REC'D BY LOCAL REG. 7-26-67

REGISTRAR'S SIGNATURE Wanda Simmons

25. EMBALMER David O. Hansen

LICENSE NO. E-510

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: SEP 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2910
Local Reg. No. 78
Reg. Dist. No. 600

BIRTH NO.

RECEIVED JUL 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN Blackfoot
c. LENGTH OF STAY (in this place) 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 01 Ada
c. CITY OR TOWN Boise
d. STREET ADDRESS (If rural, give location) 1725 Pomander Road

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	ELMER	E.	DARNELL	June	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	December 19 99	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pharmacist 21		Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alec Darnell	Kentucky	Ivetta	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Mary Payne	Med. Records-State Hospital South

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion 260X — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) unknown
DUE TO (c) Possible early diabetes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Acute brain syndrome from drug abuse

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7 June, 19 67, *to* 19 June, 1967, *that I last saw the deceased alive on* 19 June, 19 67, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Mary Louise Smith	594 MD	State Hospital South, Blackfoot	21 June '67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	June 20, 1967		Hays Kansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 5, 1967	Dorothy J. Jones	E. Dean Hill	E-466

FIRM NAME: Sandberg-Hill

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2911
Local Reg. No. 80
Reg. Dist. No. 600

Certificate of Death

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 060 Bingham 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)
c. LENGTH OF STAY (in this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route 1 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print)
a. (First) CHANDLER
b. (Middle) CARL
c. (Last) ANDERSON

4. DATE OF DEATH (Month) (Day) (Year) June 28, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH October 27, 1942

9. AGE (In years last birthday) 24
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine operator 04

10b. KIND OF BUSINESS OR INDUSTRY agriculture

11. BIRTHPLACE (State or foreign country) Butte, Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ralph Anderson
BIRTHPLACE Pleasant Hill, Missouri

14. MOTHER'S MAIDEN NAME Dora O. Chandler
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes
(If yes, give war or dates of service) 1959 to 1964 6

16. SOCIAL SECURITY NO. 517-42-4085

17. INFORMANT'S OWN SIGNATURE Ellen Anderson
ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9121

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe brain damage — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Kite in head by safety rim from tire

DUE TO (c) Blown off when inflating tire

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) farm 02

21c. (CITY, TOWN, OR TOWNSHIP) Rt #4 Blackfoot 13
(COUNTY) Bingham 061
(STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 6 24 67 10:00 a.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 28, *1967, ~~to xxxxxxxxxxxxx 19xx that I last saw the deceased xx alive on xxxxxxxxxxxxx 19xx~~, and that death occurred at* 10:00a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Carl Stoney
583 (Degree or title) Coroner, Bingham County 4

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED June 30, 67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE July 1, 1967

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) Blackfoot (State) Idaho

DATE REC'D BY LOCAL REG. July 5, 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER C. Dean Hill
LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2912
Local Reg. No. 79
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 061 Bingham, Idaho — JUL 27 1967 122
b. CITY OR TOWN Blackfoot
c. LENGTH OF STAY IN THIS PLACE 22 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. #4 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Blackfoot
d. STREET ADDRESS (If rural, give location) Rt. #4 (Groveland)

3. NAME OF DECEASED (Type or Print)
a. (First) Nora
b. (Middle) Velma
c. (Last) Adamson Adams

4. DATE OF DEATH (Month) June (Day) 29 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH April 29 1892

9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months 2 Days 0 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 07

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) American Fork, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Adamson — BIRTHPLACE Manti, Utah

14. MOTHER'S MAIDEN NAME Minnie Hansen — BIRTHPLACE American Fork, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Byron L Adams — ADDRESS Blf't, Rt 4

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic cardio-vascular disease — INTERVAL BETWEEN ONSET AND DEATH 2 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 June, 1963, *to* 29 June, 1967, *that I last saw the deceased alive on* 29 June, 1967, *and that death occurred at* 11:55 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE 234 Walter M Hoge — (Degree or title) M.D. — **23b. ADDRESS** Blackfoot, Idaho — **23c. DATE SIGNED** 7-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** July 3 1967 — **24c. NAME OF CEMETERY OR CREMATORY** Groveland Cemetery — **24d. LOCATION** (City, town, or county) (State) Groveland, Idaho

DATE REC'D BY LOCAL REG. July 5, 1967 — **REGISTRAR'S SIGNATURE** Dorothy J Jones

25. EMBALMER Howard Packham Howard Packham — **LICENSE NO.** E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

Certificate of Death

STATE OF IDAHO

State File No. 2913
Local Reg. No. 8
Reg. Dist. No. 600

RECEIVED JUL 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 06 Bingham
b. CITY OR TOWN Blackfoot
LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 06 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 267 East Pacific St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EMMER	WILLIAMS	BAKER	July 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	Widowed 2	May 15, 1897	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 07	Home	Campti, Louisiana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James M. Williams	Louisiana	Meranda V. Williams	Louisiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	4201	William Armstrong	Pocatello, [illegible], Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary occlusion	5 hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Coronary Sclerosis	5 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Chronic Emphysema Bronchial Asthma	10 yrs 10 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19 44, *to* July 4, 1967, *that I last saw the deceased alive on* July 4, 19 67, *and that death occurred at* 6:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
404	M.D.	Blackfoot, Idaho	July 7, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 8, 1967	Ashton cemetery	Ashton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 25, 1967	Dorothy D. Jones	Clare Hill	E-466

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2914
Local Reg. No. 83
Reg. Dist. No. 600

BIRTH NO.

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 061 Bingham

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot

c. LENGTH OF STAY (in this place) 1 day 301

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE 03 Arizona

b. COUNTY 555

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eloy

d. STREET ADDRESS (If rural, give location) 210 East 4th St.

3. NAME OF DECEASED (Type or Print) a. (First) Fidel b. (Middle) c. (Last) Flores

4. DATE OF DEATH (Month) (Day) (Year) July 9, 1967

5. SEX male

6. COLOR OR RACE Mexican

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH April 24, 1926

9. AGE (In years last birthday) 41 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Eagle Pass, Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Modesto Flores — BIRTHPLACE Mexico

14. MOTHER'S MAIDEN NAME Maria de Jesus — BIRTHPLACE Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 477-26-3743

17. INFORMANT'S OWN SIGNATURE Catalina Flores — ADDRESS Eloy, Arizona

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5811 Liver Failure — INTERVAL BETWEEN ONSET AND DEATH 2 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Alcoholic Cirrhosis — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 8, 1967 *to* July 9, 1967, *that I last saw the deceased alive on* July 9, 1967, *and that death occurred at* 7 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED July 11, 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE July 10, 67

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) Eloy (State) Arizona

DATE REC'D BY LOCAL REG. July 25, 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 14 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Withers

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 27 1967 Bureau of Vital Statistics

State File No. 2915
Local Reg. No. 85
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JEANETTE
b. (Middle)
c. (Last) HOSKINS

4. DATE OF DEATH (Month) (Day) (Year) July 13, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH April 4, 1892
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Burn, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Peter Jensen — BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Eda Pederson — BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-20-4392
17. INFORMANT'S OWN SIGNATURE Grant Hoskins — ADDRESS Fort Hall, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriosclerotic Heart Disease - Years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to* July 13, 19 67, *that I last saw the deceased alive on* July 13, 19 67, *and that death occurred at* 4 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE A. M. Withers 569 (Degree or title) M.D. 1
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED July 17, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE July 17, 1967
24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery
24d. LOCATION (City, town, or county) Blackfoot, (State) Idaho

DATE REC'D BY LOCAL REG. July 25, 1967
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER C. Dean Hill — LICENSE NO. E-466

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Mrs Fischer

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2916
Local Reg. No. 87
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham 403
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 3 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print)
a. (First) Fielding
b. (Middle) Lewis
c. (Last) McIntosh

4. DATE OF DEATH (Month) July (Day) 16, (Year) 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH May 5, 1908
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales manager 26
10b. KIND OF BUSINESS OR INDUSTRY Automobile
11. BIRTHPLACE (State or foreign country) Columbia Falls, Montana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles McIntosh — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Rachel Bell — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 536-07-0054
17. INFORMANT'S OWN SIGNATURE — ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary sclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967 *to* July 16, 1967, *that I last saw the deceased alive on* July 16, 1967, *and that death occurred at* 2:00a.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 404 (Degree or title) M.D. 1
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED July 18,67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 1
24b. DATE July 18,67
24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery
24d. LOCATION (City, town, or county) (State) Blackfoot, Idaho

DATE REC'D BY LOCAL REG. July 25, 1967
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER Dean Hill
LICENSE NO. E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 10 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2917
Local Reg. No. 83
Reg. Dist. No. 601

BIRTH NO.

RECEIVED JUL 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 060 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural (Blackfoot)
c. LENGTH OF STAY IN THIS PLACE 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Moreland 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Blackfoot
d. STREET ADDRESS (If rural, give location) Moreland

3. NAME OF DECEASED (Type or Print) a. (First) Margaret b. (Middle) c. (Last) Neaman

4. DATE OF DEATH (Month) July (Day) 16, (Year) 1967

5. SEX female

6. COLOR OR RACE Am. Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH August 14, 1913

9. AGE (In years last birthday) 53 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) Washakie, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nephi Perdash — BIRTHPLACE Washakie, Utah

14. MOTHER'S MAIDEN NAME Jessie Zundel — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Darlene L. Neaman — ADDRESS Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive destruction of soft tissue, fractures of bones left face and base of skull (Shotgun Wound) 981X

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. immediate death

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) homicide 3

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home 01

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Blackfoot, 13 Bingham, 061 Idaho (Moreland)

21d. TIME OF INJURY (Month) 7-16-67 (Day) (Year) (Hour) 2:00 A.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Struck at close range by shotgun blast

22. *I hereby certify that I attended the deceased from* Did not see her alive, did not attend *last saw the deceased alive on* _____, 19____, *and that death occurred at* 2:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE E. B. Webb, M.D. 555 (Degree or title)

23b. ADDRESS Pocatello, Idaho

23c. DATE SIGNED 7-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial 3

24b. DATE 7-19-67

24c. NAME OF CEMETERY OR CREMATORY Washakie Cemetery

24d. LOCATION (City, town, or county) (State) Washakie, Utah

DATE REC'D BY LOCAL REG. July 17, 1967

REGISTRAR'S SIGNATURE Dorothy G. Jones

25. EMBALMER Howard Packham — LICENSE NO. E-338

FIRM NAME: Rogers Funeral Home - Tremonton, Uta

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 3 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Violence according to acting coroner by another party

Certificate of Death

RECEIVED STATE OF IDAHO

JUL 27 1967

Bureau of Vital Statistics

State File No. 2918
Local Reg. No. 86
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham 307
b. CITY OR TOWN Blackfoot
c. LENGTH OF STAY (In this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 06
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 62½ east alice

3. NAME OF DECEASED (Type or Print)
a. (First) MONA
b. (Middle)
c. (Last) HODGE

4. DATE OF DEATH (Month) (Day) (Year) July 17, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH June 23, 1894

9. AGE (In years last birthday) 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) office supervisor 26

10b. KIND OF BUSINESS OR INDUSTRY Hospital

11. BIRTHPLACE (State or foreign country) Downs, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W. Picken
BIRTHPLACE West Virginia

14. MOTHER'S MAIDEN NAME Sarah Jane Adams,
BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-10-7579

17. INFORMANT'S OWN SIGNATURE Virginia H Becker, North Fork Idaho
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1621

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 23 June, 1967, *to* July 17, 1967, *that I last saw the deceased alive on* July 17, 1967 *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Walter G Hoge 234 (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED July 18,67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 19,67

24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. July 25, 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER John C. Sandberg
LICENSE NO. E-280
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 11 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2919
Local Reg. No. 87
Reg. Dist. No. 601

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 060 Bingham
JUL 27 1967
405
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
c. LENGTH OF STAY (In this place): 5 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence on Diggie Rd. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
d. STREET ADDRESS (If rural, give location): Rt. #2 (Thomas)

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print): a. (First) Andrew; b. (Middle) Edwards; c. (Last) Wood

4. DATE OF DEATH: (Month) July (Day) 17, (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Nov. 13, 1900

9. AGE (In years last birthday): 66; IF UNDER 1 YEAR: Months 8, Days 4; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher & Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho (Riverton)

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel Cotton Wood — BIRTHPLACE: Council Bliffs, Iowa

14. MOTHER'S MAIDEN NAME: Margaret Ann Edwards — BIRTHPLACE: Pendleton, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 519-28-8760A

17. INFORMANT'S OWN SIGNATURE: x Hudrun Wt. Wood — ADDRESS: Rt. #2 Blfs.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see him alive, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 5:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. M. Wathers 569, MD. (Degree or title)

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-21-67

24c. NAME OF CEMETERY OR CREMATORY: Riverside-Thomas Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot Rt. #2 Idaho

DATE REC'D BY LOCAL REG.: July 21, 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Howard Packham — LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

FEB 22 1973

JUL 1 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Boaster

Certificate of Death

STATE OF IDAHO

State File No. 2920
Local Reg. No. 88
Reg. Dist. No. 600

BIRTH NO.

AUG 14 1967

Bureau of Vital Statistics

302

1. PLACE OF DEATH

a. COUNTY 061 Bingham

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot

c. LENGTH OF STAY (in this place) 2 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 060 b. COUNTY Bingham

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)

d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First) ANTONIO b. (Middle) SAIZ c. (Last)

4. DATE OF DEATH (Month) July (Day) 18, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	Mexican	married 3	March 11, 1916	50				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Uvalde, Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Manuel Saiz BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME Virginia Rodriguez BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE ADDRESS Blackfoot, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH 2 Days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES XX NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 16, 1967, *to* July 18, 1967, *that I last saw the deceased alive on* July 18, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Ralph Boaster 183 (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED July 20, 67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE July 22, 1967

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) Blackfoot (State) Idaho

DATE REC'D BY LOCAL REG. July 27, 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Dean Hill

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 5 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2021
Local Reg. No. 87
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
AUG 14 1967
305
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
d. STREET ADDRESS (If rural, give location): Rt. #1

3. NAME OF DECEASED (Type or Print): a. (First) Benjamin; b. (Middle) Franklin; c. (Last) Barrus

4. DATE OF DEATH: (Month) July (Day) 19, (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: December 25, 1903

9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months 6, Days 24 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Trapper 04

10b. KIND OF BUSINESS OR INDUSTRY: State & U.S. Gov't.

11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho (Thomas)

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ruel Michael Barrus — BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Ida P. Hunter — BIRTHPLACE: Grantsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W W II 1942 4

16. SOCIAL SECURITY NO.: 519-01-7753

17. INFORMANT'S OWN SIGNATURE: Edward M. Barrus — ADDRESS: Rt. #1 Blf't.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2944

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Polycythemia — 4 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Emphysema — 5 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1967, *to* July 19 1967, *that I last saw the deceased alive on* July 14, 1967, *and that death occurred at* 1 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: P. M. Packer 404 (Degree or title): M.D. — Packer

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: 7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-22-67

24c. NAME OF CEMETERY OR CREMATORY: Groveland Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Rt. #4, Bingham, Ida.

DATE REC'D BY LOCAL REG.: July 27, 1967

REGISTRAR'S SIGNATURE: Dorothy Jo Jones

25. EMBALMER: Howard Packham

LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 2 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 10 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 14 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2922
Local Reg. No. 90
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 060 Bingham 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 05 California
b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Woodsfords
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) ARLENE b. (Middle) c. (Last) WALKER

4. DATE OF DEATH: (Month) (Day) (Year) July 20, 1967

5. SEX: Female

6. COLOR OR RACE: Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: April 9, 1966

9. AGE (In years last birthday): 1 — IF UNDER 1 YEAR: Months 3, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02

10b. KIND OF BUSINESS OR INDUSTRY: XXXX

11. BIRTHPLACE (State or foreign country): Shurne, Nevada

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lawrence Christensen — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Helen Walker — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXXX

16. SOCIAL SECURITY NO.: XXXX

17. INFORMANT'S OWN SIGNATURE: Helen Walker — ADDRESS: California

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9290

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) DROWNING — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ~~ACCIDENT~~ SUICIDE HOMICIDE (Specify) 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): HOME 01

21c. (CITY, TOWN, OR TOWNSHIP) FT HALL 13 (COUNTY) 060 (STATE) BINGHAM IDAHO

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) 7/20/67 4-4:30 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? FELL INTO DITCH

22. *I hereby certify that I attended the deceased from* ____, 19__ *to* ON JULY 20, 1967, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Thomas Stevens 584 (Degree or title) MD 1

23b. ADDRESS: Ft Hall Idaho

23c. DATE SIGNED: 7/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem-Bur 3

24b. DATE: Jul. 21, 1967

24c. NAME OF CEMETERY OR CREMATORY: Gardnerville Cemetery

24d. LOCATION (City, town, or county) (State): Gardnerville, Nevada

DATE REC'D BY LOCAL REG.: July 28 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Conway Grant — LICENSE NO.: E478

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2923
Local Reg. No. 7
Reg. Dist. No. 600

BIRTH NO.

AUG 14 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 1 hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 030 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall (Rural)
d. STREET ADDRESS (If rural, give location) Fort Hall reservation

3. NAME OF DECEASED (Type or Print) a. (First) DAVIS b. (Middle) c. (Last) PAPSE

4. DATE OF DEATH (Month) (Day) (Year) July 21, 1967

5. SEX male

6. COLOR OR RACE Am. Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 4

8. DATE OF BIRTH 1919

9. AGE (In years last birthday) 58 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Fort Hall, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Captain Papse BIRTHPLACE Boise, Idaho

14. MOTHER'S MAIDEN NAME Noddah J. Wettenbone BIRTHPLACE Incom, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. unknown

17. INFORMANT'S OWN SIGNATURE ADDRESS Fort Hall, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) 4344

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Heart attack — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) found dead in automobile
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 21, 1967, *to* ~~xxxx

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2924
Local Reg. No. 92
Reg. Dist. No. 600

BIRTH NO.

AUG 14 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Blackfoot
c. LENGTH OF STAY (in this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 45 Utah
b. COUNTY 555 Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Salt Lake
d. STREET ADDRESS (If rural, give location) 2882 S. 27th East

3. NAME OF DECEASED (Type or Print) a. (First) Bonnie b. (Middle) c. (Last) Barker

4. DATE OF DEATH (Month) (Day) (Year) July 26, 1967

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH Aug. 24, 1947

9. AGE (In years last birthday) 19 IF UNDER 1 YEAR Months 11 Days 2 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sales Clerk 25

10b. KIND OF BUSINESS OR INDUSTRY Dep't. Store

11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME F. Alvin Barker BIRTHPLACE Salt Lake City, Utah

14. MOTHER'S MAIDEN NAME Marie Pack BIRTHPLACE Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Marie P. Barker By Howard Packham ADDRESS Salt Lake City, Ut

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8224

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral laceration — INTERVAL BETWEEN ONSET AND DEATH 2½ hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto accident — 2½ hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hiway 15 06

21c. (CITY, TOWN, OR TOWNSHIP) Interchange (COUNTY) 13 (STATE) 06
2½ Mi. N. of Ft. Hall / Bingham, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-26-67 12:20A.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Car overturned

22. *I hereby certify that I attended the deceased from* 7-26-67, 19___, *to* July 26, 1967, *that I last saw the deceased alive on* July 26, 1967, *and that death occurred at* 2:55 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 403 M.D. 1

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED 7-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 7-26-67

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) Salt Lake City, (State) Utah

DATE REC'D BY LOCAL REG. Aug 9 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Howard Packham

LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 23 1967

JAN 30 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2925
Local Reg. No. 93
Reg. Dist. No. 600

RECEIVED AUG 14 1967 Bureau of Vital Statistics

BIRTH NO. 307

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 06 / Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LULA	GR ACE	WORTHEN	July 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 3	April 22, 1899	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 07	Home	Murray, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nephi McCleery	England	Eliza Seal	Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			Blackfoot, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	C.V.A.	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hypertensive heart disease	years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Rheumatic heart disease, diabetes Uremia, Cardiac decompensation	years

443X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* July 27, 19 67, *that I last saw the deceased alive on* July 27, 19 67, *and that death occurred at* 9:20 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. E. Miller Jr 361	M.D.	Blackfoot, Idaho	July 28, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	JUly 31, 1967	Groveland cemetery	Bingham county, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-9-67	Dorothy J. Jones	C. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 15 1967

JAN 29 1968

MAR 22 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2926
Local Reg. No. 30
Reg. Dist. No. 410

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 070 Blaine 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blaine County Hospital 037

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 078 Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
d. STREET ADDRESS (If rural, give location) 118 2nd Ave. South

3. NAME OF DECEASED (Type or Print)
a. (First) Arthur
b. (Middle) Craig
c. (Last) Stewart

4. DATE OF DEATH (Month) (Day) (Year) June 25, 1967

5. SEX Male
6. COLOR OR RACE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH June 15, 1966
9. AGE (In years last birthday) 1yr — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hailey, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Craig Burns Stewart — BIRTHPLACE Hailey, Idaho
14. MOTHER'S MAIDEN NAME Sharon Lee Fawsett — BIRTHPLACE Juneau, Alaska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE [signature] — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7593

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Convulsion — INTERVAL BETWEEN ONSET AND DEATH: 15 MIN

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Neurological Damage & Deficit — Since Birth
DUE TO (c) Not Known

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 June, 1966, *to* 6-25-67, 19___, *that I last saw the deceased alive on* 6-19-67, 19___, *and that death occurred at* 12 Noon *m., from the causes and on the date stated above.*

23a. SIGNATURE 402 (Degree or title) [signature]
23b. ADDRESS Hailey Idaho
23c. DATE SIGNED 7-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 26, 1967
24c. NAME OF CEMETERY OR CREMATORY Hailey Cemetery
24d. LOCATION (City, town, or county) (State) Hailey, Idaho

DATE REC'D BY LOCAL REG. Aug 4/67
REGISTRAR'S SIGNATURE Robert H. Wright per [signature]
25. EMBALMER Keith Bird [signature]
LICENSE NO. E-373

Federal Security Agency
United States Public Health Service
Form DH-63021 [initials]
FIRM NAME: Bird Funeral Home, Hailey, Ida

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

State File No. 2927
Local Reg. No. 29
Reg. Dist. No. 410

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

JUL 13 1967

1. PLACE OF DEATH
a. COUNTY 070 Blaine 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Ketchum Bureau of V
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Star Route, East Fork Big Wood River, Federal Gulch 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 05 California
b. COUNTY 555 Riverside
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Corona
d. STREET ADDRESS (If rural, give location) 223 West 8th Street

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) DOW
c. (Last) O'DONNELL

4. DATE OF DEATH (Month) (Day) (Year) July 4, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: March 7, 1915
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Variety store opr. 22
10b. KIND OF BUSINESS OR INDUSTRY: store, owner
11. BIRTHPLACE (State or foreign country): St. Thomas, Nevada
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles R O'Donnell — BIRTHPLACE: Pinto, Utah
14. MOTHER'S MAIDEN NAME: Sarah Holyoak — BIRTHPLACE: Parowan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): Navy WW 2 4201
16. SOCIAL SECURITY NO.: 530--01-1986
17. INFORMANT'S OWN SIGNATURE: Geo Lorenz O'Donnell — ADDRESS: Ely, Nevada

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: A. Scott Earle 583 Corona Mo 4 (Degree or title)
23b. ADDRESS: Sun Valley, Idaho
23c. DATE SIGNED: 7/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 7/6/67
24c. NAME OF CEMETERY OR CREMATORY: Fisher Cemetery
24d. LOCATION (City, town, or county) (State): Fisher, Arkansas

DATE REC'D BY LOCAL REG.: July 12/67
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird Keith Bird
LICENSE NO.: E- 373
FIRM NAME: Bird Funeral Home, Hailey, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021 Certified B.N.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 23 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 8 1976

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2028
Local Reg. No. 35
Reg. Dist. No. 410

RECEIVED
AUG 23 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 070 Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) near Carey
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wood River Reservoir 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 04
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 116 N. Straughan Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) STANLEY
b. (Middle) EDWARD
c. (Last) COOMBS

4. DATE OF DEATH (Month) (Day) (Year) July 22, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Feb. 28, 1908
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) custodian 01
10b. KIND OF BUSINESS OR INDUSTRY Boise Air Terminal
11. BIRTHPLACE (State or foreign country) Shelby, Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Edward Coombs — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Florence Dunster — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - - -
16. SOCIAL SECURITY NO. 518-03-8108
17. INFORMANT'S OWN SIGNATURE Lena M. Coombs — ADDRESS 116 N. Straughan Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

850X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1 Reservoir 18
21c. (CITY, TOWN, OR TOWNSHIP) 13 Little Wood Reservoir — (COUNTY) 070 Blaine — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 22 1967 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fell from boat while fishing

22. *I hereby certify that I attended the deceased from* 2 *19*__, *to* _____, *19*__, *that I last saw the deceased alive on* _____, *19*__, *and that death occurred at* 3:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE A. Scott Earle — (Degree or title) 583 M. Coroner 4
23b. ADDRESS Sun Valley, Idaho
23c. DATE SIGNED 8/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal/burial
24b. DATE 8-15-67
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) Boise — (State) Idaho

DATE REC'D BY LOCAL REG. Aug 22/67
REGISTRAR'S SIGNATURE Robert H. Wright
25. EMBALMER Ruth Bird — LICENSE NO. E-373

Federal Security Agency
United States Public Health Service
Form DH-63021 — FIRM NAME (Summers Funeral Home)

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2929
Local Reg. No. 37
Reg. Dist. No. 410

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 070 Blaine 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sun Valley
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sun Valley Hospital 23k

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 070 Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Carey
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Berle
b. (Middle) William
c. (Last) Cameron

4. DATE OF DEATH (Month) July (Day) 28 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 9, 1909

9. AGE (In years last birthday) 58
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Clerk 25

10b. KIND OF BUSINESS OR INDUSTRY Merc.

11. BIRTHPLACE (State or foreign country) Bellevue Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William H. Cameron
BIRTHPLACE Melrose, Mont

14. MOTHER'S MAIDEN NAME Isabelle Adamsen
BIRTHPLACE Heber City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-09-4096

17. INFORMANT'S OWN SIGNATURE Allen B. Cameron
ADDRESS Orem, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/28, 1967, *to* 7/28, 1967, *that I last saw the deceased alive on* 7/28, 1967, *and that death occurred at* 11:2 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 752 M.D.

23b. ADDRESS Sun Valley Idaho

23c. DATE SIGNED 8/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/1/1967

24c. NAME OF CEMETERY OR CREMATORY Carey Cemetery

24d. LOCATION (City, town, or county) Carey (State) Idaho

DATE REC'D BY LOCAL REG. Aug 4-67

REGISTRAR'S SIGNATURE Robert H. Wright

25. EMBALMER Keith Bird

LICENSE NO. E-373

FIRM NAME: Bird Funeral Home Hailey Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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6.

State File No. 2930
Local Reg. No. 86
Reg. Dist. No. 110

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 090 Bonner 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kootenai
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) inside village limits 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Avery
d. STREET ADDRESS (If rural, give location) --

3. NAME OF DECEASED (Type or Print)
a. (First) Lawrence
b. (Middle) William
c. (Last) Hibbard

4. DATE OF DEATH (Month) (Day) (Year) June 26, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Oct. 25, 1909
9. AGE (In years last birthday) 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stillman 21
10b. KIND OF BUSINESS OR INDUSTRY Pabco Refinery
11. BIRTHPLACE (State or foreign country) Rossland, B.C., Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William P. Hibbard — BIRTHPLACE Wisconwin
14. MOTHER'S MAIDEN NAME Florence M. Wilson — BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) W-W---
16. SOCIAL SECURITY NO. 559-05-2935
17. INFORMANT'S OWN SIGNATURE Estelle Jacobson — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Barry D. Nelson 583 (Degree or title) Coroner 4
23b. ADDRESS Sandpoint, Idaho
23c. DATE SIGNED 6/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 1, 1967
24c. NAME OF CEMETERY OR CREMATORY Pinecrest Cemetery
24d. LOCATION (City, town, or county) Sandpoint (State) Idaho

DATE REC'D BY LOCAL REG. July 11, 1967
REGISTRAR'S SIGNATURE Cyprus G. Tibbetts
25. EMBALMER Barry D. Nelson — LICENSE NO. E-455

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK Ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2931
Local Reg. No. 85
Reg. Dist. No. 110

BIRTH NO.

RECEIVED AUG - 2 1967 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY 090 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Priest River Rural
LENGTH OF STAY (in this place) 64 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home On Rt 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 090 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Priest River
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First) Frederick b. (Middle) Karl c. (Last) Lartz Sr.

4. DATE OF DEATH (Month) (Day) (Year) Jun 29-1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 5/12/1903
9. AGE (In years last birthday) 64
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millwork 17
10b. KIND OF BUSINESS OR INDUSTRY Lumber
11. BIRTHPLACE (State or foreign country) Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME August C. Lartz BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Caroline Brodback BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-01-6141
17. INFORMANT'S OWN SIGNATURE Alice P. Lartz ADDRESS Priest River Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 8-1963
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Essential Hypertension — 1963

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 23, 1967, to June 29, 1967, that I last saw the deceased alive on 6-23, 1967, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE Carlton Evans MD (Degree or title)
23b. ADDRESS Newport, Wash.
23c. DATE SIGNED 7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/3/1967
24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery
24d. LOCATION (City, town, or county) Priest River, Idaho (State)

DATE REC'D BY LOCAL REG. July 11, 1967
REGISTRAR'S SIGNATURE Phyllis G. Roberts
25. EMBALMER L E Sherman
LICENSE NO. OL 685

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sherman Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 9 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2932
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 090 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hope
LENGTH OF STAY (in this place): 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 090 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hope
d. STREET ADDRESS (If rural, give location): --

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	Louisa	Hepker	June 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Nov. 24, 1890	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	Own Home	Rushmore, Ohio	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel G. Hildebrand	unobtainable	Lucy Hildebrand	Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	--	430-20-3978	X W. R. Hepker	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden Death - Ventricular Fibrodation — INTERVAL BETWEEN ONSET AND DEATH: unk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease — Progress
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. DIABETES — 3 1/2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4/17/60, 19__, *to* 6/30, 1967, *that I last saw the deceased alive on* Jun 26, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Frances Anderson M 471	Spokane Idaho	8/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL 3	June 30, 1967	Hazen & Jaeger Funeral Home	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Phyllis Y. Tibbetts	L. G. Moon, Jr.	E-501

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Moon Funeral Home

DUTIES:

AUG 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2933
Local Reg. No. 88
Reg. Dist. No. 110

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG - 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 091 Bonner 203

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint

c. LENGTH OF STAY (in this place) 3 mos

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 090

b. COUNTY Bonner

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Priest River

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)

a. (First) Luther b. (Middle) Bert c. (Last) Davis

4. DATE OF DEATH (Month) (Day) (Year) July 2 1967

5. SEX M

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH 3/17/1879

9. AGE (In years last birthday) 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY Lumber

11. BIRTHPLACE (State or foreign country) Wisconsin

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Clarence Davis — BIRTHPLACE Unobtainable

14. MOTHER'S MAIDEN NAME Caroline Drake — BIRTHPLACE Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 5/8 03 9797

17. INFORMANT'S OWN SIGNATURE Leroy Davis — ADDRESS Reardan, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

157X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of pancreas — INTERVAL BETWEEN ONSET AND DEATH 2 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 16, 1967, *to* July 2, 1967, *that I last saw the deceased alive on* July 1, 1967, *and that death occurred at* 12:35 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 327 (Degree or title) [signature] MD

23b. ADDRESS Sandpoint, Idaho

23c. DATE SIGNED 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/6/67

24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery

24d. LOCATION (City, town, or county) (State) Priest River Idaho

DATE REC'D BY LOCAL REG. July 24, 1967

REGISTRAR'S SIGNATURE [signature]

25. EMBALMER R. D. Sherman — LICENSE NO. QL 749

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Sherman Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2934
Local Reg. No. 87
Reg. Dist. No. 110

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 091 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
c. LENGTH OF STAY (in this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 090 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Colburn
d. STREET ADDRESS (If rural, give location) Box 51

3. NAME OF DECEASED (Type or Print)
a. (First) Claude
b. (Middle) Cecil
c. (Last) Green

4. DATE OF DEATH (Month) (Day) (Year) July 13, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 22, 1879
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Section Foreman 18
10b. KIND OF BUSINESS OR INDUSTRY retired
11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Columbus Green — BIRTHPLACE Tennessee
14. MOTHER'S MAIDEN NAME Margaret May — BIRTHPLACE Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 701-12-6317
17. INFORMANT'S OWN SIGNATURE Lillian N Green — ADDRESS

18. CAUSE OF DEATH 4341
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pneumonia - uremia — INTERVAL BETWEEN ONSET AND DEATH: Out 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — several
DUE TO (c) and Chronic Bronchitis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 11, 1957, *to* July 13, 1967, *that I last saw the deceased alive on* July 13, 1967, *and that death occurred at* 6:20 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 471 (Degree or title)
23b. ADDRESS Sandpoint Idaho
23c. DATE SIGNED July 29 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 17, 1967
24c. NAME OF CEMETERY OR CREMATORY Pinecrest Cemetery
24d. LOCATION (City, town, or county) Sandpoint (State) Idaho

DATE REC'D BY LOCAL REG. July 24, 1967
REGISTRAR'S SIGNATURE Phyllis G. Tibbetts
25. EMBALMER Dale G. Coffelt — LICENSE NO. E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2935
Local Reg. No. 89
Reg. Dist. No. 110

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG - 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 091 Bonner 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 090 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Priest River
d. STREET ADDRESS (If rural, give location): 4th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Louis
b. (Middle): J.
c. (Last): Peloquin

4. DATE OF DEATH (Month) (Day) (Year): July 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: Sept. 18, 1898
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph H. Peloquin — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Emma Dupree — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 536-09-0488 A
17. INFORMANT'S OWN SIGNATURE: Albert Peloquin — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Upper G I hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): duodenal ulcer — 1 year
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: arterio-sclerotic heart disease — 5 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [ ] NO [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): - - - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): - - - - - - - - - -
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - - - - m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: -

22. *I hereby certify that I attended the deceased from* July, 1966, *to* July 18, 1967, *that I last saw the deceased alive on* July 18, 1967, *and that death occurred at* 7:05 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 327 [signature] MD
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 7-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
24d. LOCATION (City, town, or county) (State): Priest River, Idaho

DATE REC'D BY LOCAL REG.: July 26, 1967
REGISTRAR'S SIGNATURE: Phyllis Y. Tibbetts
25. EMBALMER: Dale G. Coffey
LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2936
Local Reg. No. 96
Reg. Dist. No. 110

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 091 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 10 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 1123 Church Street

3. NAME OF DECEASED (Type or Print)
a. (First): Anthony
b. (Middle): Robert
c. (Last): Brill

4. DATE OF DEATH (Month) (Day) (Year): July 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 7, 1885
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired manager of 26 pole yard
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Juliet, Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Brill — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 518-20-2532
17. INFORMANT'S OWN SIGNATURE: Bernice B. Lewis — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: same

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-17, 1967, *to* 7-25, 1967 *that I last saw the deceased alive on* 7-17, 1967, *and that death occurred at* 8:20 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 327 W. Marenau MD
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Aug. 14, 1967
REGISTRAR'S SIGNATURE: Phyllis G. Tibbetts
25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2937
Local Reg. No. 94
Reg. Dist. No. 110

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 090 Bonner 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coolin
c. LENGTH OF STAY (in this place): 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home on Priest Lake 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: Whitman 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rosalia
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Viola Curtis James

4. DATE OF DEATH (Month) (Day) (Year): July 28-1967

5. SEX: Female
6. COLOR OR RACE: Cacu.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb 7-1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Curtis — BIRTHPLACE: Tennessee
14. MOTHER'S MAIDEN NAME: Lula Stratton — BIRTHPLACE: TENNESSEE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 539-24-6846-A
17. INFORMANT'S OWN SIGNATURE: Mark James — ADDRESS: Rosalia Wash

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 3:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Barry D. Nelson 583 Coroner 4
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 8-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 7/28/1967
24c. NAME OF CEMETERY OR CREMATORY: Sherman Funeral Home
24d. LOCATION (City, town, or county) (State): Newport, Wash.

DATE REC'D BY LOCAL REG.: Aug 14, 1967
REGISTRAR'S SIGNATURE: Phyllis Y. Pelletier
25. EMBALMER: Howard G. Jaeger
LICENSE NO.: 01462

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: JAEGER FUNERAL HOME - ROSALIA, WASH.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: OCT 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2938
Local Reg. No. 92
Reg. Dist. No. 110

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 091 Bonner 309
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
LENGTH OF STAY (in this place) 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 090
b. COUNTY Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kootenai
d. STREET ADDRESS (If rural, give location) --

3. NAME OF DECEASED (Type or Print)
a. (First) Martin
b. (Middle)
c. (Last) Stromgren

4. DATE OF DEATH (Month) (Day) (Year) July 30, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Feb. 6, 1881
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Own Farm 04
10b. KIND OF BUSINESS OR INDUSTRY: Bee farm
11. BIRTHPLACE (State or foreign country): Sweden (Vedjeon, Stromsund)
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jonas Eric Stromgren — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Morit Nelson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 518-42-5013A
17. INFORMANT'S OWN SIGNATURE: U. P. Stromgren — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carbo vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) arterio sclerosis — 10 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

442X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1, 1967, *to* July 30, 1967, *that I last saw the deceased alive on* July 29, 1967, *and that death occurred at* 4:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE: J. B. Monenau 327 (Degree or title) MD
23b. ADDRESS: Sandpoint, Ida
23c. DATE SIGNED: 8-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Lakeview Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Aug. 14, 1967
REGISTRAR'S SIGNATURE: Phyllis G. Tibbetts
25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2939
Local Reg. No. 93
Reg. Dist. No. 110

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 090 Bonner 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rt 6 Priest River
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McAbee Falls 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Wash b. COUNTY 555 Pend Oreille
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Newport
d. STREET ADDRESS (If rural, give location) Rt. 4

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lawrence	James	Edgar	July 30 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	10/29/1945	21				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Farm	Newport Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Glenn Edgar	Nebraska	Lettie Dickenson	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518 52 6614	Koleen L Edgar	Priest River

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Accidental drowning
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	McAbee Falls 78	Priest River 13	Bonner 090	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
July 30, 1967 3:45 PM		Swam to save unidentified girl

22. *I hereby certify that I attended the deceased from* 2 *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Danny D. Nelson 583 Coroner	Sandpoint, Idaho	8-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/3/67	Evergreen Cemetery	Priest River Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 14, 1967	Lucille Y. Tibbetts	R. D. Sherman	QL749

Federal Security Agency
United States Public Health Service
Form PH-63021

FIRM NAME Sherman Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 13 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

SEP 9 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 11 2005

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

John Hatch

RECEIVED JUL 26 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2940
Local Reg. No. 34
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenview Chalet Convalescent Home 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1053 Pacific

3. NAME OF DECEASED (Type or Print)
a. (First) AMANDA
b. (Middle) LANDON
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) February 10, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Sept. 21, 1891
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months 5 Days 8 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Stone, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Antone Fredrick Sorensen — BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Mary Jane Johnston — BIRTHPLACE Stone, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Darrell Landon — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bronchial with emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18, 1963, *to* 2-9, 1967, *that I last saw the deceased alive on* 2-9, 1967, *and that death occurred at* 2:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE John S Hatch MD 210 (Degree or title)
23b. ADDRESS
23c. DATE SIGNED 2/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 2/14/67
24c. NAME OF CEMETERY OR CREMATORY Fielding Mem. Park
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho.

DATE REC'D BY LOCAL REG. 2/16/67
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Leo A. Williams — LICENSE NO. E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2941
Local Reg. No. 231
Reg. Dist. No. 610

Certificate of Death

RECEIVED
AUG 24 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF [illegible] (If [illegible] place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley,
d. STREET ADDRESS (If rural, give location) R#1

3. NAME OF DECEASED (Type or Print)
a. (First) Rex
b. (Middle) Lloyd
c. (Last) Park

4. DATE OF DEATH (Month) June (Day) 14 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Nivermarried
8. DATE OF BIRTH Sept. 21, 1914
9. AGE (In years last birthday) 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Jameston, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hugh Park — BIRTHPLACE Mill Creek Utah
14. MOTHER'S MAIDEN NAME Bertha Bolton — BIRTHPLACE Granger Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-10-9959
17. INFORMANT'S OWN SIGNATURE J Arthur Park — ADDRESS R#1 Shelley, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

6000

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart failure

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Chronic pyelonephritis

DUE TO (c) generalized cachexia

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: many years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1963, *to* June 14, 1967, *that I last saw the deceased alive on* June 14, 1967, *and that death occurred at* 4 A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 339 (Degree or title) MD
23b. ADDRESS Shelley Idaho
23c. DATE SIGNED 8/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 6-17-67
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State) Idaho Falls, Bonneville, Idaho

DATE REC'D BY LOCAL REG. Aug. 17-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER [signature] M Nalder
LICENSE NO. E275

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Nalder Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 5 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2942
Local Reg. No. 202
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN Idaho Falls
c. LENGTH OF STAY (in this place) 38 years
d. FULL NAME OF HOSPITAL OR INSTITUTION Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 100 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Idaho Falls
d. STREET ADDRESS (If rural, give location) St. Leon Road

3. NAME OF DECEASED (Type or Print) a. (First) HAZEL b. (Middle) (NMN) c. (Last) NORDELL

4. DATE OF DEATH (Month) June (Day) 14 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH December 26, 1898

9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 07

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Grover, Colorado

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James G. Fisher — BIRTHPLACE No record

14. MOTHER'S MAIDEN NAME Amanda Puckett — BIRTHPLACE No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-46-7497

17. INFORMANT'S OWN SIGNATURE Leona M. Johnson — ADDRESS Idaho Falls, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial insufficiency (Cardiac insufficiency) — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary insufficiency — Unknown
DUE TO (c) Occlusive arterial disease — Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 7, 1956 *to* June 14, 1967, *that I last saw the deceased alive on* June 14, 1967, *and that death occurred at* 12:10P m., *from the causes and on the date stated above.*

23a. SIGNATURE 0447 Leonard J. Bingham (Degree or title) M. D.

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED July 17, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE June 18, 1967

24c. NAME OF CEMETERY OR CREMATORY Linn Grove Cemetery

24d. LOCATION (City, town, or county) Weld County (State) Colorado

DATE REC'D BY LOCAL REG. July 19-1967

REGISTRAR'S SIGNATURE Anna Rudges

25. EMBALMER Orland C. Buck

LICENSE NO. E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2943
Local Reg. No. 777
Reg. Dist. No. 610

RECEIVED JUL 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place) 57 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 353 N. Emerson Avenue 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 353 N. Emerson Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) JAMES
b. (Middle) (NMN)
c. (Last) MUIR

4. DATE OF DEATH (Month) (Day) (Year) June 28 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: November 26, 1901
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Plano, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Alexander Muir — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Catherine McGilivray — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-05-9954
17. INFORMANT'S OWN SIGNATURE: Elda M Muir — ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4201 Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-16-1962 *to* 6-28, 1967, *that I last saw the deceased alive on* 5-2-, 1967, *and that death occurred at* 7:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 348 (Degree or title) M. D.
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 1, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: July 19 1967
REGISTRAR'S SIGNATURE: Emma Rodgers
25. EMBALMER: Orland C Buck
LICENSE NO. E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-630a

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

Dr. McMillin

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2944
Local Reg. No. 187
Reg. Dist. No. 610

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16
b. COUNTY Bonneville 103
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Iona
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Martha
b. (Middle) Ann
c. (Last) Rushton

4. DATE OF DEATH (Month) (Day) (Year) July 1 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH February 11, 1882
9. AGE (In years last birthday) 85
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Ogden, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John J. Ritchie
BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Harriett Coop
BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE James R. Rushton
ADDRESS Iona, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 203X Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture of right humerus
Fracture of right pelvis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 28 June, 1967, *to* 1 July, 1967, *that I last saw the deceased alive on* 1 July, 1967, *and that death occurred at* 7:35 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Tim O. Johnson 262 (Degree or title) MD
23b. ADDRESS Idaho Falls Idaho
23c. DATE SIGNED 8 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/5/67
24c. NAME OF CEMETERY OR CREMATORY Iona Cemetery
24d. LOCATION (City, town, or county) Iona (State) Idaho

DATE REC'D BY LOCAL REG. July 13-1967
REGISTRAR'S SIGNATURE Anna Brefgee
25. EMBALMER Ralph M. Wood Ralph M. Wood
LICENSE NO. 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JUL 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2945
Local Reg. No. 185
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF STAY (in this place) 11 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 260
b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Lewisville
d. STREET ADDRESS (If rural, give location) East of Lewisville

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) ELIZABETH KINGHORN

4. DATE OF DEATH (Month) (Day) (Year) July 2, 1967

5. SEX F. M.
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Aug. 13, 1880
9. AGE (In years last birthday) 86 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY X
11. BIRTHPLACE (State or foreign country) Clarkston, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin Harris, Jr. BIRTHPLACE
14. MOTHER'S MAIDEN NAME Mary Ann Morton BIRTHPLACE Wellsville, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) X
16. SOCIAL SECURITY NO. 518-60-2070
17. INFORMANT'S OWN SIGNATURE Joseph A. Kinghorn ADDRESS Rigby, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 72 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 15 years
DUE TO (c) Arteriosclerotic Heart Disease — 12 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arthritis Deformans — 35 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1939, *to* July 2, 1967, *that I last saw the deceased alive on* July 1, 1967, *and that death occurred at* 10:20 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE 521 (Degree or title) Aldon Tall, M.D.
23b. ADDRESS Rigby, Idaho
23c. DATE SIGNED 7/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Jul. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Lewisville
24d. LOCATION (City, town, or county) (State) Lewisville, Jefferson, Idaho

DATE REC'D BY LOCAL REG. July 10-1967
REGISTRAR'S SIGNATURE Anna Budgen
25. FUNERAL DIRECTOR Bruce A. Eckersell ADDRESS Rigby, Idaho
Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of Bruce A. Eckersell Lic. No. E-404 at Rigby, Idaho. on 7/2/1967

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2946
Local Reg. No. 191
Reg. Dist. No. 610

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
DURATION OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 220 b. COUNTY Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
d. STREET ADDRESS (If rural, give location) R. F. D.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RUSSELL	J.	HOWELL	July 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	28 May 1924	43				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Warm River, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David T. Howell	Dinglebell, Idaho	Zina Iowa Gunter	Barkers Creek N.C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWII 4 8254	519-30-2048	[signature]	Ashton Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Multiple Injuries
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2 Jul 67	Severe injuries - Body - chest - ter	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
accident	Home 06	Ashton 13 Fremont 21 Idaho	m.		auto

22. *I hereby certify that I attended the deceased from* 2 July, 1967, *to* 2 Jul, 1967, *that I last saw the deceased alive on* 2 Jul, 1967, *and that death occurred at* 9:20 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	230	339 - 24th	12 Jul 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	5 July 1967	Pineview Cemetery	Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 17 '67	[signature]	[signature]	E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2947
Local Reg. No. 204
Reg. Dist. No. 610

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY IN (this place): 59 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): 360 Basalt Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CRAWFORD	FREDERICK	ANDERSON	July	3	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	October 6, 1880	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Warehouseman 77	Agricultural Mach.	Fayette Township Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gilbert J. Anderson	Norway	Emma Bertha Million	Lafayette Co., Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-09-1406	Mrs. Frank Rose Anderson	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

163X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes — Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-15-, 19 67 *to* 6-30-, 19 67, *that I last saw the deceased alive on* 6-30-, 19 67, *and that death occurred at* 4:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John Holton 210	M. D.	Idaho Falls, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 6, 1967	Fielding Memorial Park	Bonneville County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-1967	Anna Rudge	Orland C. Buck	E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 23 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SDH JUN 26 2017

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2948
Local Reg. No. 182
Reg. Dist. No. 611

RECEIVED
JUL 12 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 100 Bonneville 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Irwin
c. LENGTH OF STAY (in this place) 10 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 100 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Irwin
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Joseph
b. (Middle)
c. (Last) Park

4. DATE OF DEATH (Month) July (Day) 4 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 9, 1898
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superviser 26
10b. KIND OF BUSINESS OR INDUSTRY 4H Camp
11. BIRTHPLACE (State or foreign country) LaBelle, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME David Harvey Park — BIRTHPLACE USA
14. MOTHER'S MAIDEN NAME Lucy Jane Scott — BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT'S OWN SIGNATURE Glen J Park — ADDRESS Irwin Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* 151X
(a) Cancer of stomach with metastasis — INTERVAL BETWEEN ONSET AND DEATH 18 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (Clinical diagnosis - palpable mass in epigastrium of abdomen)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/29/67, 19__, *to* 6/19, 1967, *that I last saw the deceased alive on* 6/19, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 723 S. H. Worthen MD (Degree or title)
23b. ADDRESS Afton, Wyoming
23c. DATE SIGNED July 5, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/6/67
24c. NAME OF CEMETERY OR CREMATORY Cedar Butte Cemetery
24d. LOCATION (City, town, or county) Annis Jefferson Co. (State) Idaho

DATE REC'D BY LOCAL REG. July 7-1967
REGISTRAR'S SIGNATURE Anna Bridger
25. EMBALMER Ralph M. Wood Ralph M. Wood — LICENSE NO. 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63020

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 19 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2949
Local Reg. No. 193
Reg. Dist. No. 6/D

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 221 Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony, Idaho
d. STREET ADDRESS (If rural, give location) 42 West 2nd North

3. NAME OF DECEASED (Type or Print)
a. (First) MIRIAM
b. (Middle) MOG
c. (Last) GAU

4. DATE OF DEATH (Month) (Day) (Year) July 7, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 10, 1909

9. AGE (In years last birthday) 57
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ellsworth County, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert Mog
BIRTHPLACE Ellsworth County, Kan

14. MOTHER'S MAIDEN NAME Mary Strella
BIRTHPLACE Ellsworth County, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 527-01-1751

17. INFORMANT'S OWN SIGNATURE Morgan T. Gau
ADDRESS St. Anthony, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CHEMICAL PERITONITIS & SHOCK — INTERVAL BETWEEN ONSET AND DEATH: 5411

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) PERFORATED DUODENAL ULCER

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. PULMONARY EMPHYSEMA

19a. DATE OF OPERATION 7-6-67

19b. MAJOR FINDINGS OF OPERATION PERFORATED DUODENAL ULCER, 18 HOURS PREVIOUSLY

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JULY 6, 1967 *to* JULY 7, 1967, *that I last saw the deceased alive on* JULY 7, 1967, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 081 J. H. Carr MD FACS

23b. ADDRESS 756 Oxford Idaho Falls

23c. DATE SIGNED 7-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11 July 67

24c. NAME OF CEMETERY OR CREMATORY Wilford Cemetery

24d. LOCATION (City, town, or county) (State) St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG. July 12-67

REGISTRAR'S SIGNATURE Anna Rudge

25. EMBALMER Mark Hansen

LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM; In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2950
Local Reg. No. 192
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

BIRTH NO. RE

AUG - 1 1967

Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Id[redacted]
c. LIMITS OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 394 West 17th St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): 394 West 17th St.

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle):
c. (Last): Johnston

4. DATE OF DEATH (Month) (Day) (Year): July 7, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 9, 1896
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Seattle, Washington
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: ? BIRTHPLACE
14. MOTHER'S MAIDEN NAME: ? BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-36-3496
17. INFORMANT'S OWN SIGNATURE: Winnona Johnston — ADDRESS: 394 W. 17th Idaho Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2001

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 7/14/~~64~~ 64

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1957, 19__, *to* 7/7/67, 19__, *that I last saw the deceased alive on* July 1, 1967, *and that death occurred at* 4:35 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H E Guyett MD 194
23b. ADDRESS: Idaho Falls, Ida
23c. DATE SIGNED: 7/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 10, 1967
24c. NAME OF CEMETERY OR CREMATORY: Basalt, Idaho
24d. LOCATION (City, town, or county) (State): Bingham Idaho

DATE REC'D BY LOCAL REG.: July 17-67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Lloyd M. Nalder — LICENSE NO.: E 275
FIRM NAME: Nalder Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK INK under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2951
Local Reg. No.
Reg. Dist. No.

RECEIVED JUL 26 1967 Bureau of Vital Statistics

BIRTH NO. 67-7462

1. PLACE OF DEATH
a. COUNTY Bonneville
b. CITY OR TOWN Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION LDS Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville
c. CITY OR TOWN Idaho Falls
d. STREET ADDRESS (If rural, give location) Route 5

3. NAME OF DECEASED (Type or Print): a. (First) Jill b. (Middle) Albertson c. (Last)

4. DATE OF DEATH (Month) (Day) (Year): July 7, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)

8. DATE OF BIRTH: July 7, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 0

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Idaho Falls, Ida

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ronald D. Albertson
BIRTHPLACE: Idaho Falls

14. MOTHER'S MAIDEN NAME: Norma Dow
BIRTHPLACE: Basset, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Ronald Albertson
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Premature Labor
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/7, 1967, *to* 7/7, 1967, *that I last saw the deceased alive on* 7/7, 1967, *and that death occurred at* 9:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Nelson Falls M.D.

23b. ADDRESS: Rigby, Idaho

23c. DATE SIGNED: 7/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 10, 1967

24c. NAME OF CEMETERY OR CREMATORY: Grant Cemetery

24d. LOCATION (City, town, or county) (State): Grant Idaho

DATE REC'D BY LOCAL REG.: 7-26-67

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Geo A. Sullivan

LICENSE NO.: E-319

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2952
Local Reg. No.
Reg. Dist. No.

BIRTH NO. 67-7463

RECEIVED JUL 26 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 216.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L D S Hospital #42

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route 5

3. NAME OF DECEASED (Type or Print): a. (First) Jody b. (Middle) Albertson c. (Last)

4. DATE OF DEATH: (Month) (Day) (Year): July 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):
8. DATE OF BIRTH: July 7, 1967
9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Ronald D. Albertson — BIRTHPLACE: Idaho Falls
14. MOTHER'S MAIDEN NAME: Norma Dant — BIRTHPLACE: Basalt, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Ronald Albertson — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity. — INTERVAL BETWEEN ONSET AND DEATH: 24 weeks Gestation.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Premature labor
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/7, 1967, *to* 7/7, 1967, *that I last saw the deceased alive on* 7/7, 1967, *and that death occurred at* 9:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Odon Udall, M.D. (Degree or title)
23b. ADDRESS: Rigby, Idaho
23c. DATE SIGNED: 7/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 10 1967
24c. NAME OF CEMETERY OR CREMATORY: Grant Cemetery
24d. LOCATION (City, town, or county) (State): Grant, Idaho

DATE REC'D BY LOCAL REG.: 7-26-67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Lee A Williams
LICENSE NO.: E-319
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2953
Local Reg. No. 231
Reg. Dist. No. 610

RECEIVED AUG 15 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 101
b. CITY OR TOWN Idaho Falls
b. (If outside corporate limits, write RURAL and give township) (In this place) 8 months
d. FULL NAME OF HOSPITAL OR INSTITUTION Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 320
b. COUNTY Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Ashton
d. STREET ADDRESS (If rural, give location) 12 miles east of Ashton

3. NAME OF DECEASED (Type or Print)
a. (First) ARNOLD
b. (Middle) CHRISTIAN
c. (Last) KUHNRATH

4. DATE OF DEATH (Month) July (Day) 8 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 7

8. DATE OF BIRTH October 20, 1888

9. AGE (In years last birthday) 78
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Livestock 04

10b. KIND OF BUSINESS OR INDUSTRY Self employed

11. BIRTHPLACE (State or foreign country) Custer County, Colorado

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Carsten Kuhnrath
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Sophie Steen
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) World War I 3

16. SOCIAL SECURITY NO. 544-10-1664

17. INFORMANT'S OWN SIGNATURE Clara S. Kuhnrath
ADDRESS Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Liposarcoma Retroperitoneal — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION April 1967

19b. MAJOR FINDINGS OF OPERATION Abdominal tumor - Liposarcoma

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 14, 19 61, *to* July 8, 19 67, *that I last saw the deceased alive on* July 8, 19 67, *and that death occurred at* 2:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE 104 G.W. Corbett, (Degree or title) M. D.

23b. ADDRESS 798 South Blvd. Idaho Falls, Idaho

23c. DATE SIGNED July, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial

24b. DATE July 11,67

24c. NAME OF CEMETERY OR CREMATORY Lutheran Cemetery (Squirrel)

24d. LOCATION (City, town, or county) Fremont County (State) Idaho

DATE REC'D BY LOCAL REG. Aug 12 67

REGISTRAR'S SIGNATURE Anna Rudge

25. EMBALMER Orland C. Buck

LICENSE NO. E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 5 1967

OCT 26 1967

JAN 8 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

Dr. Tom Cecil

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2954
Local Reg. No. 198
Reg. Dist. No. 610

BIRTH NO.

RECEIVED JUL 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN Idaho Falls
c. LENGTH OF STAY IN THIS PLACE 2 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 190 Custer
c. CITY OR TOWN Mackay
d. STREET ADDRESS (If rural, give location) 311 Park Ave.

3. NAME OF DECEASED (Type or Print) a. (First) BRUCE b. (Middle) c. (Last) HILL

4. DATE OF DEATH (Month) (Day) (Year) July 8, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 29, 1917
9. AGE (In years last birthday) 49 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Malad, Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Edward N. Hill BIRTHPLACE St. John, Idaho
14. MOTHER'S MAIDEN NAME Annie Evans BIRTHPLACE Malad, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-01-1720
17. INFORMANT'S OWN SIGNATURE x Sheba Hill ADDRESS Mackay, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 9361 brain stem dysfunction — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral edema — 2+ months
DUE TO (c) intracerebral hemorrhage — 2+ months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 5-16-67
19b. MAJOR FINDINGS OF OPERATION intracerebral hemorrhage on left + Cerebral edema
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT [X] SUICIDE [ ] HOMICIDE [ ] (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) farm 02
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) (STATE) Idaho
21d. TIME OF INJURY (Month) 5 (Day) (Year) 67 (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? accidental head injury

22. I hereby certify that I attended the deceased from 5-16, 1967, to 7-8, 1967, that I last saw the deceased alive on 7-7, 1967, and that death occurred at 3:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE George L. Barnard MD 027 (Degree or title)
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 7-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-11-67
24c. NAME OF CEMETERY OR CREMATORY Malad City Cemetery
24d. LOCATION (City, town, or county) Malad, Idaho (State)

DATE REC'D BY LOCAL REG. July 15-1967
REGISTRAR'S SIGNATURE Emma Bradley
25. EMBALMER C. A. Marvel
LICENSE NO. E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2955
Local Reg. No. 206
Reg. Dist. No. 616

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JUL 27 1967 000

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Green View Chalet Rest Home 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle)
c. (Last) Crooks

4. DATE OF DEATH (Month) July (Day) 8 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH March 27, 1871
9. AGE (In years last birthday) 96 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) American Fork, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Crooks — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Ann Stormont — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Niles C Crooks — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes mellitus — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 3 yrs.
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-29, 1965, *to* 7-8, 1967, *that I last saw the deceased alive on* 6-15, 1967, *and that death occurred at* 2 p *m., from the causes and on the date stated above.*

23a. SIGNATURE X S Blair Ellsworth 156 (Degree or title)
23b. ADDRESS 1106 S. Blvd., Idaho Falls, Ida.
23c. DATE SIGNED 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/11/67
24c. NAME OF CEMETERY OR CREMATORY HillCrest Cemetery
24d. LOCATION (City, town, or county) Shelley (State) Idaho

DATE REC'D BY LOCAL REG. July 21-67
REGISTRAR'S SIGNATURE Anna Budge
25. EMBALMER Lloyd M. Nalder — LICENSE NO. E 275

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 2956
Local Reg. No. 199
Reg. Dist. No. 611

RECEIVED JUL 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 100 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Idaho Falls
LENGTH OF STAY (in this place) 16 yrs.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1030 9th Street

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6 miles North on West River Rd.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	ROBERT	GERALD	MERRELL		July	10	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	June 27, 1946	21				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	University	Poplar Bluff, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gerald D. Merrell	Doniphan, Missouri	Mary K. Praxel	Redwood Falls, Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Mary K. Merrell	Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	TRAUMATIC CRUSH INJURIES TO CHEST & HEAD 8254	MINUTES
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	SINGLE CAR AUTOMOBILE ACCIDENT	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	BLOOD ALCOHOL WAS 1.74 MG/CC POSTMORTEUM	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
ACCIDENT	26	IDAHO FALLS 13 BONNEVILLE 10 IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 Hazel L McCaffey M.D. HAZEL L. MC CAFFEY, M. D. M.D., Coroner	Idaho Falls, Idaho	7/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 13, 1967	Fielding Memorial Park	Bonneville County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 17-1967	Anna Bridges	Orland C. Buck	E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2957
Local Reg. No. 203
Reg. Dist. No. 610

RECEIVED JUL 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 61 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 068 b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley, Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	William	Henry	Kunter	July	11	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	30 July 1877	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant 22
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hanover, Germany
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Kunter	Germany	Anna Lohmeyer	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 07 5177
17. INFORMANT'S OWN SIGNATURE Mrs. E. E. Pierce ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 157 Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with metastases

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-53, *to* 7-11, 19 67, *that I last saw the deceased alive on* 7-11, 1967, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 416 (Degree or title)
23b. ADDRESS Shelley, Idaho
23c. DATE SIGNED 7/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 14 1967
24c. NAME OF CEMETERY OR CREMATORY Hill Crest
24d. LOCATION (City, town, or county) Shelley, Bingham (State) Idaho

DATE REC'D BY LOCAL REG. July 19-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER L. M. Nalder [signature] LICENSE NO. E. 275
FIRM NAME: Nalder's Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

67-7954

BIRTH NO.

RECEIVED

JUL 21 1967

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2958
Local Reg. No. 797
Reg. Dist. No. 610

1. PLACE OF DEATH

a. COUNTY 101 Bonneville 302

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls

c. LENGTH OF STAY (in this place) 2

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 260

b. COUNTY Jefferson

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ririe

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)

a. (First) MARTY

b. (Middle) GEORGE

c. (Last) FREEMAN

4. DATE OF DEATH (Month) (Day) (Year) July 13, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH July 10, 1967

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 3 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Rexburg, Idaho

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME George Floyd Freeman BIRTHPLACE Idaho Falls, Idaho

14. MOTHER'S MAIDEN NAME Lanta Erickson BIRTHPLACE Rexburg, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE George F Freeman ADDRESS Ririe, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7545

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital Heart Disease

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) (A) Fruncus Arteriosus (B) COMMON Ventricle.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE T. Mitchell 746 (Degree or title) M.D. 1

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED 7/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/15/67

24c. NAME OF CEMETERY OR CREMATORY Ririe Shelton

24d. LOCATION (City, town, or county) (State) Ririe Bonneville Idaho

DATE REC'D BY LOCAL REG. July 15-1967

REGISTRAR'S SIGNATURE Anna Bridges

25. EMBALMER Kenneth R Flamm

LICENSE NO. E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. A W Brunt

Certificate of Death

STATE OF IDAHO

State File No. 2959
Local Reg. No. 284
Reg. Dist. No. 61

BIRTH NO.

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 360 Oneida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad
d. STREET ADDRESS (If rural, give location) 550 North 500 West St.

3. NAME OF DECEASED (Type or Print) a. (First) DORA b. (Middle) MAXWELL c. (Last) APGOOD

4. DATE OF DEATH (Month) July (Day) 13 (Year) 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 17, 1887
9. AGE (In years last birthday) 80 If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 07
10b. KIND OF BUSINESS OR INDUSTRY --
11. BIRTHPLACE (State or foreign country) PEOA, UTAH
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ralph Wallace Maxwell BIRTHPLACE Peoa, Utah
14. MOTHER'S MAIDEN NAME Elizabeth Fannie Walker BIRTHPLACE Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-58-9509
17. INFORMANT'S OWN SIGNATURE Flora A. Allen ADDRESS Ogden, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-14-, 1967, to 7-14, 1967, that I last saw the deceased alive on 7-14, 1967, and that death occurred at 5 p m., from the causes and on the date stated above.

23a. SIGNATURE A. Wm Brunt Jr. MD 633 (Degree or title)
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7-14-67
24c. NAME OF CEMETERY OR CREMATORY Malad City Cemetery
24d. LOCATION (City, town, or county) Malad, Idaho (State)

DATE REC'D BY LOCAL REG. July 25 '67
REGISTRAR'S SIGNATURE Emma Budge
25. EMBALMER Rafael H. Benson
LICENSE NO. E-351

FIRM NAME: Benson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 9 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 12 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2960
Local Reg. No. 101
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 10/ Bonneville 137
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 37 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16 b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 575 Wabash

3. NAME OF DECEASED (Type or Print) a. (First) MURIEL b. (Middle) VETIE c. (Last) HUNT

4. DATE OF DEATH (Month) July (Day) 13 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH October 22, 1891

9. AGE (In years last birthday) 75 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 07

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Owen Sound, Ontario

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown Patterson BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs. [illegible] Hunt ADDRESS Salt Lake City, Utah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic & Rheumatic heart disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Heat exhaustion

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1962, 19__, *to* July 3, 1967, *that I last saw the deceased alive on* July 3, 1967 *and that death occurred at* 5:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE Byron T Weeks 556 (Degree or title) M. D.

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 15, 1967

24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

24d. LOCATION (City, town, or county) Idaho Falls (State) Idaho

DATE REC'D BY LOCAL REG. July 19-1967

REGISTRAR'S SIGNATURE Emma Rudger

25. EMBALMER Orland C. Buck

LICENSE NO. E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63621

DUTIES:

DEC 3 0 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

6465

BIRTH NO.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2961
Local Reg. No. 222
Reg. Dist. No. 610

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 411
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1067 Sahara

3. NAME OF DECEASED (Type or Print)
a. (First) JACK
b. (Middle) BLAIR
c. (Last) ELLSWORTH III

4. DATE OF DEATH (Month) July (Day) 13 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: July 12, 1967
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 0, Days 0 — IF UNDER 24 HRS.: Hours 11, Min. 14

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jack Blair Ellsworth II — BIRTHPLACE: California
14. MOTHER'S MAIDEN NAME: Jacqueline Lundahl — BIRTHPLACE: Idaho Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Jack B. Ellsworth Jr. — ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7735

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hyalin membrane disease
DUE TO (c) Premature rupture of placenta

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Bonneville, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-12, 1967, *to* 7-13, 1967, *that I last saw the deceased alive on* 7-13, 1967, *and that death occurred at* 4:40A. *m., from the causes and on the date stated above.*

23a. SIGNATURE: K B Blair Ellsworth 156 (Degree or title) M. D. 1
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemeter y
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Aug. 12-67
REGISTRAR'S SIGNATURE: Anna Bredgier
25. EMBALMER: [signature]
LICENSE NO.: E-387

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2962
Local Reg. No. 223
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
AUG 15 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY IN this place 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 300
b. COUNTY Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Florence
b. (Middle) Louise
c. (Last) Moats

4. DATE OF DEATH (Month) (Day) (Year) July 14, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Jan. 14, 1891

9. AGE (In years last birthday) 76
If UNDER 1 YEAR Months / Days
If UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floral Shop 22

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Smith-Cumberland, England
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Mary Louise Russell-Salt Lake City, Utah
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. yes

17. INFORMANT'S OWN SIGNATURE Joseph L. Moats
ADDRESS Salmon, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1530 Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Cecum — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 28, 1967, *to* July 14, 1967, *that I last saw the deceased alive on* July 13, 1967, *and that death occurred at* 12:37 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE 294 L. K. Krantz (Degree or title) M. D.

23b. ADDRESS 798 South Blvd. Idaho Falls, Idaho

23c. DATE SIGNED July , 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-18-67

24c. NAME OF CEMETERY OR CREMATORY Salmon

24d. LOCATION (City, town, or county) (State) Salmon, Idaho

DATE REC'D BY LOCAL REG. Aug. 12-67

REGISTRAR'S SIGNATURE Anna Budge

25. EMBALMER Orland C. Beck

LICENSE NO. E-250

FIRM NAME: Jones Funeral Home, Salmon, Idaho

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Lincoln County

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2963
Local Reg. No. 239
Reg. Dist. No. 611

BIRTH NO.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 100 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Idaho Falls
LENGTH OF STAY (in this place) 0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1/2 mile East St. Leon School

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 26
b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Grant
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	MARTIN	ORVILLE	HARRIS		July	15	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	Sept. 17, 1903	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Farm	Lewisville, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Martin Harris	Kirtland, Ohio	Mary Ann Morton	Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518-12-6189	Mrs. Carl (Marva) Brown	Rigby, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) STENOSIS, SEVERE, ANTERIOR DESCENDING

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

BRANCH OF THE LEFT CORONARY ARTERY ; MODERATE OF RIGHT BRANCHES.

DUE TO (b) ARTERIOSCLEROSIS, CORONARY ARTERIES & GENERALIZED.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* NODULAR HYPERPLASIA OF PROSTATE

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) NONE

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hazel L. McGaffey M.D. HAZEL L. MC GAFFEY, M.D., Coroner	Idaho Falls, Idaho	8/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE 1967	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal & Burial	July 19	Lewisville Cemetery	Jefferson County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 12 '67	Anna Bridges	Orland C. Buck	E-250

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home, Idaho Falls, Ida.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 14 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2964
Local Reg. No. 285
Reg. Dist. No. 210

BIRTH NO.

RECEIVED JUL 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY (10) Bonneville 000
b. CITY OR TOWN Idaho Falls
c. LENGTH OF STAY in this place
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY (10) Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1405 Sage Avenue

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Henry c. (Last) Thompson

4. DATE OF DEATH (Month) July (Day) 16, (Year) 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH June 22, 1890

9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY Carpenter

11. BIRTHPLACE (State or foreign country) Conejos County, Colorado

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE John Henry Wise Thompson, Mercer Co., Va.

14. MOTHER'S MAIDEN NAME BIRTHPLACE Elizabeth Catherine Sanders Obin Cr., Va

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO. 519-03-1468

17. INFORMANT'S OWN SIGNATURE Ida M. Thompson ADDRESS Blackfoot, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1637 Cancer of Lung — INTERVAL BETWEEN ONSET AND DEATH 6 Months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. terminal infection, etc.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* July, 1967, *that I last saw the deceased alive on* July 10, 1967, *and that death occurred at* 9:40 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Harvey A. Hatch 208 (Degree or title) M.D.

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/20/67

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) (State) Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG. July 22-67

REGISTRAR'S SIGNATURE Emma Rudge

25. EMBALMER Howard Packham

LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2965
Local Reg. No. 203
Reg. Dist. No. 610

RECEIVED JUL 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 10 Bonneville 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 19 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 27 Montana
b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dillon
d. STREET ADDRESS (If rural, give location) 120 South Atlantic

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) R c. (Last) DEPUTY

4. DATE OF DEATH (Month) (Day) (Year) July 16, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH October 5, 1897

9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher 21

10b. KIND OF BUSINESS OR INDUSTRY Self Employed

11. BIRTHPLACE (State or foreign country) Dillon, Montana

12. CITIZEN OF WHAT COUNTRY? USA USA

13. FATHER'S NAME Charles H Deputy BIRTHPLACE Delaware

14. MOTHER'S MAIDEN NAME Katherine Kadletz BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 516 36 8297 A

17. INFORMANT'S OWN SIGNATURE Mrs. Georgia Deputy ADDRESS Dillon, Montana

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5020

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema, obstructive type

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute + Chronic Tracheobronchitis

DUE TO (c) Cor Pulmonale

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Bilateral hydropneumothorax

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____ 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 5:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE F. Mitchell L.P.D. Hosp. (Degree or title) Idaho Falls M.D.

23b. ADDRESS L.P.D. Hosp. Idaho Falls, Idaho

23c. DATE SIGNED 7/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal & Burial 7/16/67

24b. DATE

24c. NAME OF CEMETERY OR CREMATORY Mt View Cemetery

24d. LOCATION (City, town, or county) Dillon, Montana (State)

DATE REC'D BY LOCAL REG. July 18 67

REGISTRAR'S SIGNATURE Emma Rudges

25. EMBALMER Jack A. Wood, Jr. LICENSE NO. 396

FIRM NAME: WOOD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RN Mitchell

Certificate of Death

STATE OF IDAHO

State File No. 2966
Local Reg. No. 207
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG - 1 1967 000

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 500 Blk - Qda Que. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonnev ille
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 175 Wadsworth Drive

3. NAME OF DECEASED (Type or Print)
a. (First) Dee
b. (Middle) J.
c. (Last) Olsen

4. DATE OF DEATH (Month) (Day) (Year) July 17, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Jan. 25, 1926
9. AGE (In years last birthday) 41 — IF UNDER 1 YEAR Months 5 Days 22 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY Automotive parts
11. BIRTHPLACE (State or foreign country) Mink Creek Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Ariel L. Olsen — BIRTHPLACE Mink Creek, Ida.
14. MOTHER'S MAIDEN NAME Emma Johnson — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) War 2 4
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Ariel Lamar Olsen — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombus, recent, anterior descending branch, L coronary artery

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) Arteriosclerosis, coronary arteries

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE T. Mitchell 746 (Degree or title) M.D.
23b. ADDRESS L.D.S. Hosp. Idaho Falls, Ida.
23c. DATE SIGNED 7/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 20, 1967
24c. NAME OF CEMETERY OR CREMATORY Milo Cemetery
24d. LOCATION (City, town, or county) Idaho Falls, Ida. (State) Route 1

DATE REC'D BY LOCAL REG. July 25-67
REGISTRAR'S SIGNATURE Emma Budger
25. EMBALMER Geo A. Williams
LICENSE NO. E-319

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2967
Local Reg. No. 211
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1875 North Holmes Ave 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 818 Sonja

3. NAME OF DECEASED (Type or Print)
a. (First) Rex
b. (Middle) Dwane
c. (Last) Matesen

4. DATE OF DEATH (Month) (Day) (Year) 7-19-67

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 3-5-35
9. AGE (In years last birthday) 32 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 21
10b. KIND OF BUSINESS OR INDUSTRY Electrical Co.
11. BIRTHPLACE (State or foreign country) Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME H. Clifton Matesen — BIRTHPLACE USA
14. MOTHER'S MAIDEN NAME LaVela Iverson — BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 529-46-9598
17. INFORMANT'S OWN SIGNATURE Mrs Rex D Matesen — ADDRESS Idaho Falls Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9363

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) severe & multiple skull fractures

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Trauma

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT ✓ SUICIDE HOMICIDE (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Warehouse 03
21c. (CITY, TOWN, OR TOWNSHIP) Idaho Falls 13 (COUNTY) Bonneville 101 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8 p m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Working on parade float & bails of barbed wire fell on him

22. *I hereby certify that I attended the deceased from* 2 *, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE D. H. Baker 018 M.D. (Degree or title)
23b. ADDRESS Idaho Falls
23c. DATE SIGNED 7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Rem 3
24b. DATE 7-22-67
24c. NAME OF CEMETERY OR CREMATORY Brigham City Cemetery
24d. LOCATION (City, town, or county) (State) Brigham City, Utah

DATE REC'D BY LOCAL REG. July 31-67
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Jack A. Wood
LICENSE NO. E396

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2968
Local Reg. No. 212
Reg. Dist. No. 610

BIRTH NO. AUG - 3 1967

1. PLACE OF DEATH
a. COUNTY 101 Bonneville Bureau of Vital Statistics 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 301 9th Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 301 9th Street

3. NAME OF DECEASED (Type or Print)
a. (First) EVA
b. (Middle) S
c. (Last) HOLLAND

4. DATE OF DEATH (Month) (Day) (Year) July 20, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH December 31, 1902
9. AGE (In years last birthday) 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Waynesburrough, Mississippi
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lester Smith — BIRTHPLACE Mississippi
14. MOTHER'S MAIDEN NAME Sue Luella Smith — BIRTHPLACE Mississippi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT'S OWN SIGNATURE C. W. Holland — ADDRESS Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

465X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1964, *to* July 20, 1967, *that I last saw the deceased alive on* July 19, 1967, *and that death occurred at* 1:15 a *m., from the causes and on the date stated above.*

23a. SIGNATURE Byron T Weeks MD 556 (Degree or title)
23b. ADDRESS 1585 S. Boulevard
23c. DATE SIGNED 7/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/22/67
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. July 31 - 67
REGISTRAR'S SIGNATURE Anne a Bridges
25. EMBALMER Jack A. Wood, Jr. — LICENSE NO. 396
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2969
Local Reg. No. 214
Reg. Dist. No. 610

Certificate of Death

RECEIVED AUG 1 1 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 Marion Hotel-Idaho Falls, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location) ✓

3. NAME OF DECEASED (Type or Print)
a. (First) Roscoe
b. (Middle) Carlyle
c. (Last) Hix

4. DATE OF DEATH (Month) (Day) (Year) July 23, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Dec. 2, 1967
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sate of Idaho Employee
10b. KIND OF BUSINESS OR INDUSTRY 08
11. BIRTHPLACE (State or foreign country) Grant, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James C. Hix — BIRTHPLACE Harrisville, Utah
14. MOTHER'S MAIDEN NAME Bessie Helm — BIRTHPLACE Price, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-10-245
17. INFORMANT'S OWN SIGNATURE X Blanche Shreffler — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5811 prob metabolic acidosis & liver failure 4 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 2° chronic alcoholic cirrhosis — INTERVAL BETWEEN ONSET AND DEATH 1 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1965, *to* death, 19__, *that I last saw the deceased alive on* 1 wk before death, 19__, *and that death occurred at* 4 p *m., from the causes and on the date stated above.*

23a. SIGNATURE A. Wm Brunt Jr MD 633 (Degree or title)
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 27, 1967
24c. NAME OF CEMETERY OR CREMATORY Grant Cemetary
24d. LOCATION (City, town, or county) (State) Grant, Jefferson, Idaho

DATE REC'D BY LOCAL REG. Aug. 3-1963
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Leo A. Williams — LICENSE NO. E-319

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2970
Local Reg. No. 215
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Idaho Falls,
c. STATE (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho Falls L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 934 "J" Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Hazel	Fridal	Wright	July 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	married 3	March 30, 1895	72	3	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Bear River City, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Knud H. Fridal	Denmark	Mary Hansen Fridal	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-26-2016	x Warren E. Wright	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilary Cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) pericholangiolitis
DUE TO (c) Ulcerative Colitis — 8 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May, 19 66, *to* July 23, 19 67, *that I last saw the deceased alive on* July 22, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bryant Weeks	556 M D	1585 So Boulevard	7/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 26, 1967	Fielding Memorial Park	Idaho Falls, Idaho Co. Bonneville

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 3-1967	Anna Snelgrove	Leo A. Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-630a

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 5 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2971
Local Reg. No. 216
Reg. Dist. No. 610

RECEIVED AUG 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 07 BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) IDAHO FALLS LDS HOSPITAL 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 22 FREMONT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ST. ANTHONY
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ELNORA	COOPER	SIMMONS BIRCH	July 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Caucasian	Widow 2	March 31, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Vineyard, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert F. Cooper	Penna	Amelia C. Larsen	Fairview, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Vay C Simmons	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 5603 Cardio-Vasc collapse — Interval between onset and death: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Cardiac decomp. — hours
DUE TO (c) Surgical correction massive Ventral Hernia — days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Marked emaciation at least — months.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
22 Jul 67	Incarcerated massive Ventral Hernia	YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 15 Jul, 1967, *to* Death, *that I last saw the deceased alive on* 24 Jul, 1967, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas Kapp	230 MD	539 - 2nd St	31 Jul 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	27 July 67	Wilford Cemetery	St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 2 - 67	Anna Rudges	M. L. Hansen	E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

#1867

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2972
Local Reg. No. 210
Reg. Dist. No. 610

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 101 Bonneville AUG 15 1967 124
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls — Bureau of Vital Statistics
LENGTH OF STAY (in this place) 24 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16 b. COUNTY 19 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 900 Memorial Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	MARY	ETTA	STALKER	July	26	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	April 23, 1872	95				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife, retired
10b. KIND OF BUSINESS OR INDUSTRY: 61 Own home
11. BIRTHPLACE (State or foreign country): Hillsboro, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Joseph Flake — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Dora May Barringer — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-60-6300
17. INFORMANT'S OWN SIGNATURE: Mrs Maurine Carlson ADDRESS Idaho Falls Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diverticulitis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 25, 19 55, *to* July 26, 19 67, *that I last saw the deceased alive on* July 24, 19 67, *and that death occurred at* 11:05A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
294 L. K. Krantz, M. D.	798 South Blvd. Idaho Falls, Idaho	8/ / 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	July 29, 1967	Pineview Cemetery	Ashton Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 12-67	Emma Burgess	Orland C. Buck	E-250

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 11 1967 Bureau of Vital Statistics

State File No. 2973
Local Reg. No. 217
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
STAY (in this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 160 Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mackay
d. STREET ADDRESS (If rural, give location) Beverland Lane

3. NAME OF DECEASED (Type or Print) a. (First) Chris b. (Middle) 042 c. (Last) Nelson

4. DATE OF DEATH (Month) (Day) (Year) July 26, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 24, 1883
9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 84
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Montpelier, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lars Nelson BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Unobtainable BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 519-24-1449
17. INFORMANT'S OWN SIGNATURE X Robert W. Nelson ADDRESS Mackay, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4648 Massive Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH 5 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Phlebothrombosis of Pelvic Veins — secondary to recent
DUE TO (c) left surgery.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 7/5/67
19b. MAJOR FINDINGS OF OPERATION Non-Union of Femoral Neck Fracture.
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/4, 1967, *to* 7/26/67, 19___, *that I last saw the deceased alive on* 7/26, 19___, *and that death occurred at* 1017 m., *from the causes and on the date stated above.*

23a. SIGNATURE 463 (Degree or title)
23b. ADDRESS 500 Walnut Idaho Falls, Idaho
23c. DATE SIGNED 7/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-29-67
24c. NAME OF CEMETERY OR CREMATORY Mt. McCaleb Cemetery
24d. LOCATION (City, town, or county) Mackay (State) Idaho

DATE REC'D BY LOCAL REG. Aug 2 67
REGISTRAR'S SIGNATURE Anna Budge
25. EMBALMER E. H. Marvel
LICENSE NO. E-457
FIRM NAME Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service
Form DH-63024

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 2974 2979
Local Reg. No. 610
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 12 Bonneville 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 290 West Crowley Street 001

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16 b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 290 West Crowley Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Laura	Leah	Lockard	July	26	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married 7	May 5, 1967		2	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02	None	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Lockard	Nebraska	Linda Taylor	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	John L Lockard	Idaho Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) ETIOLOGY UNDETERMINED (So Called Crib Death) — INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* None Found

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
None	In Car At Home	IDAHO FALLS	BONNEVILLE	IDAHO

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
			m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 HAZEL L. MC CAFFEY, M. D. CORONER	2525 South Boulevard Ave, I.F.	8/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	7/29/67	Fielding Memorial Park	Idaho Falls	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 5-67	Anna Bridges	Ralph M. Wood Ralph M Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: D-67-4328

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 2975
Local Reg. No. 273
Reg. Dist. No. 610

AUG - 3 1967

STATE OF IDAHO

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 501 L Street

3. NAME OF DECEASED (Type or Print)
a. (First) Edward
b. (Middle) Merrill
c. (Last) Owens

4. DATE OF DEATH (Month) July (Day) 26 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 11, 1903
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Potato Growers
11. BIRTHPLACE (State or foreign country): Woodville, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Robert Owens — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Mary Louise Lamoreaux — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 10 0132
17. INFORMANT'S OWN SIGNATURE: Leona Dees — ADDRESS: 3210 E. 24th

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3222

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Hemorrhagic Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Alcoholism
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21, 1967, *to* 7-26, 1967, *that I last saw the deceased alive on* 7-26, 1967 *and that death occurred at* 5 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: Farrel Hansen 200 (Degree or title)
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 7/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/31/67
24c. NAME OF CEMETERY OR CREMATORY: Teton City Cemetery
24d. LOCATION (City, town, or county) (State): Teton City Idaho

DATE REC'D BY LOCAL REG.: July 31 - 67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood — LICENSE NO. 413

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Wood Funeral Home

AUG 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2976
Local Reg. No. 209
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN Idaho Falls
LENGTH OF STAY (in this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville 108
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Idaho Falls
d. STREET ADDRESS (If rural, give location) 1/4 mile east of St. Leon School

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	NELLIE	M.	LAMONT	July	27	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	May 5, 1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own home	Lincoln, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Henry McFarland	No record	No record	No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-46-0455	Dean M. Lamont	Idaho Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4200 / 4 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2/8, 19 66, *to* 7/27, 19 67, *that I last saw the deceased alive on* 7/27, 19 67 *and that death occurred at* 9:50A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	546 M.D.	Idaho Falls, Idaho	8/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	July 29, 1967	Pineview Cemetery	Ashton Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 12-1967	Anna Budge	[signature]	E-250

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 2977
Local Reg. No. 220
Reg. Dist. No. 610

RECEIVED AUG 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Idaho Falls
DURATION OF STAY (in this place): 10 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 525 East 17th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 525 East 17th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Nora	Lavern	Dieterle	July 27 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	July 20, 1907	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Plymouth, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Erastus Harper Rudd — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Lucy Ray Lamb — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 22 8109
17. INFORMANT'S OWN SIGNATURE: Joseph H. Dieterle — ADDRESS: Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 20 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Recent Cerebral Thrombosis — 3 weeks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1967, *to* July 27, 1967, *that I last saw the deceased alive on* July 27, 1967, *and that death occurred at* 7P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Byron T Weeks MD — 556 (Degree or title)
23b. ADDRESS: 1585 So Boulevard
23c. DATE SIGNED: 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/1/67
24c. NAME OF CEMETERY OR CREMATORY: Ammon Cemetery
24d. LOCATION (City, town, or county): Ammon (State): Idaho

DATE REC'D BY LOCAL REG.: Aug. 5-1967
REGISTRAR'S SIGNATURE: Irma Rudges
25. EMBALMER: Ralph M. Wood — Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 1 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2978
Local Reg. No. 219
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 002
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 300 block of C St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 577 E. 15 th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Doris	Leone	Everitt	July 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 3	23 March 1930	37				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		San antonio, Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Daniel Thornton	Texas	"Beulah Lott	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Beulah L. Thornton	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) GUNSHOT HEMOTHORAX, BILATERAL, MASSIVE WITH EXSANGUINATION

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) LACERATION OF DESCENDING THORACIC AORTA

DUE TO (c) GUNSHOT WOUND TO THORAX

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. TOTAL OF THREE BULLET WOUNDS, THORAX

INTERVAL BETWEEN ONSET AND DEATH: 2-3 MIN

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	ABDOMEN AND LEFT WRIST.	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
HOMOCIDE 3	300 Block C St. I.F.	IDAHO FALLS 13	BONNEVILLE 101	IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Person certifying)	23b. ADDRESS	23c. DATE SIGNED
Hazel L. McGaffey M.D. HAZEL L. McGAFFEY, M. D. CORONER	2525 SOUTH BOULEVARD AVE, I.F.	8/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
?Burial	Aug 2, 1967	Ammon Cemetery	Ammon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 23-67	Anna Rudge	Leo A Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2979
Local Reg. No. 225
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 07 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Greenview Chalet Nursing Home 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 07 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 385 Cleveland

3. NAME OF DECEASED (Type or Print): a. (First) Lewis; b. (Middle) (Lew); c. (Last) Berrett

4. DATE OF DEATH: (Month) July (Day) 29 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: June 21 1883

9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): North Ogden, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel F. Berrett — BIRTHPLACE: USA

14. MOTHER'S MAIDEN NAME: Elizabeth Newby — BIRTHPLACE: USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-07-4766

17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: 385 Cleveland

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 42201 arteriosclerotic Heart — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): disease with
DUE TO (c): Coronary insufficiency + Thrombosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-30-, 19 47 *to* July 29 1967, *that I last saw the deceased alive on* 7-18, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: John Halter — (Degree or title): MD — **23b. ADDRESS**: Idaho Falls — **23c. DATE SIGNED**: 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 8/1/67 — **24c. NAME OF CEMETERY OR CREMATORY**: Cedar Butte Cemetery — **24d. LOCATION** (City, town, or county) (State): Annis Idaho

DATE REC'D BY LOCAL REG.: Aug 9-1967 — REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Ralph M. Wood [signature] — LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2980
Local Reg. No. 226
Reg. Dist. No. 610

RECEIVED AUG 15 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 10/ Bonneville 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY IN (this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 10/ Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 2593 West Broadway

3. NAME OF DECEASED (Type or Print): a. (First) Berdett b. (Middle) Elden c. (Last) Hope

4. DATE OF DEATH: (Month) July (Day) 30 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: August 27, 1952

9. AGE (In years last birthday): 14
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: Jr. High School

11. BIRTHPLACE (State or foreign country): Rigby, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Keppner Elden Hope
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Joan Hunter
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Elden Hope
ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

2043

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Leukemia, Lymphatic, acute — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Tonsillitis — Probable septicemia — 1 week

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 2, 1967, *to* July 30, 1967, *that I last saw the deceased alive on* July 30, 1967, *and that death occurred at* 4:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ronald K. Rockhold M.D.
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 8/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/3/67
24c. NAME OF CEMETERY OR CREMATORY: Rexburg Cemetery
24d. LOCATION (City, town, or county) (State): Rexburg Idaho

DATE REC'D BY LOCAL REG.: Aug. 9-1967
REGISTRAR'S SIGNATURE: Anna Rudge

25. EMBALMER: Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2981
Local Reg. No. 31-67
Reg. Dist. No. 100

Certificate of Death

RECEIVED
JUL 12 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 110 Boundary 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 1 hr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Herman Lake 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 110
b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) P. O. Box #251

3. NAME OF DECEASED (Type or Print)
a. (First) DANNY
b. (Middle) LeROY
c. (Last) GLAUNER

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 7
8. DATE OF BIRTH Sept. 28, 1949
9. AGE (In years last birthday) 17 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) Bonners Ferry, Idaho
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Chester Glauner — BIRTHPLACE Hagerman, Idaho
14. MOTHER'S MAIDEN NAME Irene Henslee — BIRTHPLACE Chadwick, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Jack W. Glauner — ADDRESS Box 251, Bonners Ferry, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by drowning — INTERVAL BETWEEN ONSET AND DEATH 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Herman Lake 18
21c. (CITY, TOWN, OR TOWNSHIP) Bonners Ferry 13 — **(COUNTY)** Boundary 110 — **(STATE)** Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 3, 1967 1P.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Drowned while swimming

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, *19*___, *to* ___, *19*___, *that I last saw the deceased alive on* ___, *19*___, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE C. McCallahan 583 (Degree or title) Coroner 4
23b. ADDRESS Bonners Ferry
23c. DATE SIGNED 7/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 7/7/67
24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery
24d. LOCATION (City, town, or county) Bonners Ferry — (State) Idaho

DATE REC'D BY LOCAL REG. July 7, 1967
REGISTRAR'S SIGNATURE Cecyla Stone
25. EMBALMER Charles D. Malone
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2982
Local Reg. No. 32-67
Reg. Dist. No. 100

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 110 Boundary 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 110
b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) North Bench

3. NAME OF DECEASED (Type or Print)
a. (First) FRANK
b. (Middle) CHAMBERLAIN
c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 3, 1903
9. AGE (In years last birthday) 63 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) City Employee 08
10b. KIND OF BUSINESS OR INDUSTRY Maintenance
11. BIRTHPLACE (State or foreign country) Scotland, South Dakota
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Frank P. Johnson — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Rosamond Hall — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 540-12-4430
17. INFORMANT'S OWN SIGNATURE Alberta H. Johnson — ADDRESS Bonners Ferry Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 157X Massive bowel hemorrhage — INTERVAL BETWEEN ONSET AND DEATH Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinomatosis — 1 yr
DUE TO (c) Ca. of pancreas — 1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Aug. 1966
19b. MAJOR FINDINGS OF OPERATION Ca. of pancreas & Metastases to lungs.
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/3, 1966, *to* 7/3, 1967, *that I last saw the deceased alive on* July 3rd, 1967, *and that death occurred at* 4:28 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Fred W. Durose 150 (Degree or title) M. D. 1
23b. ADDRESS P. O. Box #388 Bonners Ferry, Idaho 83805
23c. DATE SIGNED 7-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-7-67
24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery
24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. July 10, 1967
REGISTRAR'S SIGNATURE Gwyla Stone
25. EMBALMER Charles A. Balmer
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 10 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2983
Local Reg. No. 33-67
Reg. Dist. No. 100

BIRTH NO.

RECEIVED
JUL 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN: Bonners Ferry
d. FULL NAME OF HOSPITAL OR INSTITUTION: DOA Community Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary 110
c. CITY OR TOWN: Bonners Ferry
d. STREET ADDRESS (If rural, give location): Route #1

LENGTH OF STAY (in this place): 30 years

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOSEPH	LINCOLN	EBY	July 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Divorced 4	May 26, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 84	Agriculture	Norden, Nebraska	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Eby	Norden, Nebraska	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		[signature]	Bonners Ferry, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Callahan 583	Coroner 4	Bonners Ferry, Idaho	7/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/12/67	Grandview Cemetery	Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1967	Freyda Stone	[signature]	E-453

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 26 1999

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 2984
Local Reg. No. 34-67
Reg. Dist. No. 100

BIRTH NO.

AUG 10 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
LENGTH OF STAY (in this place) 68 yrs 168
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home; Route #1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Boundary 110
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HENRY	PETER	WENDEL	July 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married 7	12/28/97	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	griculture	Rhinelander, Wisconsin	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Wendel	Germany	Mary Goldbeck	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-5472	Loretta Johnston	Bonners Ferry Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertension — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* INVESTIAGTION ONLY, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Callahan 583	Coroner 4	Bonners Ferry, Idaho	8/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/2/67	Grandview Cemetery	Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 5, 1967	Loretta Stone	Charles Malone	E-453

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

AUG 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased. AUG 11 1967
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained ~~from the local registrar in the district~~ WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour ~~of the day at which death occurred.~~ And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2985 35289
Local Reg. No. 100
Reg. Dist. No.

BIRTH NO.

AUG 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 110 Boundary 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Evergreen Court 100

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 357
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 639-28th Street, North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HORACE	LEO	MUNDELL	July 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	9/9/1894	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bee Keeper 04	Commercial	Oklahoma City, Oklahoma	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James O. Mundell	New York	Marrilla E. Henshaw	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-10-8904	Juliaetta Horace E. Mundell	Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* INVESTIAGION ONLY, 19____, to _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Callahan 583	Coroner 4	Bonners Ferry, Idaho	7/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7/30/67	Brower-Wann Funeral Chapel	Lewiston Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 5, 1967	Loyola Stone		E-453

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

AUG 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 2986
Local Reg. No. 7
Reg. Dist. No. 670

BIRTH NO.

RECEIVED STATE OF IDAHO

JUL 18 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 120 Butte
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco
c. LENGTH OF STAY (In this place) 17 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 200 Blk on Arco Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 120 Butte
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco
d. STREET ADDRESS (If rural, give location) 200 Blk on Arco Ave

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Dominick c. (Last) Mellen

4. DATE OF DEATH (Month) (Day) (Year) July 10, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 3

8. DATE OF BIRTH Oct. 31, 1900

9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter 11

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Drummond, Montana

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Dominick H. Mellen BIRTHPLACE Unobtainable

14. MOTHER'S MAIDEN NAME Mary Margaret Russell BIRTHPLACE Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 516-10-7716

17. INFORMANT'S OWN SIGNATURE x Margaret Neel ADDRESS Portland, Oregon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Case not diagnosed-Probable Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* As Coroner Only-Did not see alive, 19____; *to* ____, 19____; *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 11:00 PM *from the causes and on the date stated above.*

23a. SIGNATURE C. H. Marvel 583 (Degree or title) Butte County Coroner

23b. ADDRESS Arco, Idaho

23c. DATE SIGNED July 14, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-14-67

24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State) Arco, Idaho

DATE REC'D BY LOCAL REG. 7-15-1967

REGISTRAR'S SIGNATURE Betty J. Marvel

25. EMBALMER C. H. Marvel

LICENSE NO. E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2987
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 120 Butte 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco
LENGTH OF STAY (in this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lost Rivers Hospital 964

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 190 Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Challis
d. STREET ADDRESS (If rural, give location) Main Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DAVID	ELIAS	EDMISTON	July 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 12, 1890	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 84	Ranching	Smithfield, Utah	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Warren Edmiston	Manti, Utah	Lucy Ann Hamilton	Cache Valley, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	526-32-0889	x Agnes W. Edmiston	Challis, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease - 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Myocardial insufficiency 6 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 1960, *to* 7-10, 1967, *that I last saw the deceased alive on* 7-10, 1967, *and that death occurred at* 10:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. Rader M.D.		Arco Ida	7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	7-12-67	Elliott-Wilson	Wilson, Wyoming

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-9-1967	Betty L. Marvel	C. K. Marvel	E-457

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2338
Local Reg. No. 170
Reg. Dist. No. 362

RECEIVED JUL 26 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
COUNTY 142 Canyon
b. CITY OR TOWN Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 142 Canyon
c. CITY OR TOWN Nampa
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) c. (Last) BLECHA

4. DATE OF DEATH (Month) June (Day) 3, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 20, 1881
9. AGE (In years last birthday) 85 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Podlesen, Czechoslovakia Bohemia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Franz Hrebenar BIRTHPLACE Bohemia
14. MOTHER'S MAIDEN NAME Anna Palous BIRTHPLACE Bohemia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 56 7825 J
17. INFORMANT'S OWN SIGNATURE Frank Blecha ADDRESS Nampa, Idaho

4200

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Osteoporosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Vulva 1957 (Cured)

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1966 *to* June, 1967, *that I last saw the deceased alive on* May 24, 1967, *and that death occurred at* 7:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE Raymond Olson 115 (Degree or title)
23b. ADDRESS Nampa Ida
23c. DATE SIGNED 7-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) Nampa (State) Idaho

DATE REC'D BY LOCAL REG. July 22 1967
REGISTRAR'S SIGNATURE Jane Finch
25. EMBALMER Richard W. Mesenbrink License No. E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2989
Local Reg. No. 9
Reg. Dist. No. 360

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkview Manor Nursing Home 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 2315 Michigan

3. NAME OF DECEASED (Type or Print)
a. (First): Joseph
b. (Middle): B.
c. (Last): Cress

4. DATE OF DEATH (Month) (Day) (Year): June 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 10, 1881
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Johnson City, Tenn.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Cress — BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Ritta Hall — BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-16-5393A
17. INFORMANT'S OWN SIGNATURE: Charles M. Cress — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebrovascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized ASHD
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 7, 19 67, *to* June, 19 67, *that I last saw the deceased alive on* June 7, 1967, *and that death occurred at* 2:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Graydon Olson M.D. 115 (Degree or title)
23b. ADDRESS: Nampa Ida
23c. DATE SIGNED: 8-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Aug. 7, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E-508

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2990
Local Reg. No. 10
Reg. Dist. No. 360

BIRTH NO.

AUG 8 - 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION PARKVIEW MANOR 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN Nampa
d. STREET ADDRESS (If rural, give location) 411 Garland

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	PEARL		WRIGHT	June 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	April 12, 1886	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Ret. Farmer 04	Farming	Near King City	Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jacob Wright	Illinois	Eva Baher	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 05 5558A	R. J. Wright	Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Osteoarthritis

INTERVAL BETWEEN ONSET AND DEATH: ½-36 hrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 19 61, *to* June, 19 67, *that I last saw the deceased alive on* June, 19 67, *and that death occurred at* 11:06A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hayden Olson	MD	Nampa Ida	8-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 3, 1967	Hillcrest Cemetery	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 7, 1967	Mrs. Martina Walmsley	William K. Rice, Jr.	E-513

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 2991
Local Reg. No. 10
Reg. Dist. No. 360

RECEIVED
JUL 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 14 Canyon
b. CITY OR TOWN Caldwell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 44 Texas
b. COUNTY 553
c. CITY OR TOWN San Juan Texas
d. STREET ADDRESS (If rural, give location) San Juan, Texas

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	PETRA	M	LARA	7	1	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	Mexican	Married 3	8/ 1/ 1911	55				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	housewife	San Luis Potosi, Mexico	Mexico

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no	Lewis A. Lara	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1750 Carcinomatosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ca ovary
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-9-67, 19___, *to* 7-1-67, 19___, *that I last saw the deceased alive on* 7-1-67, 19___, *and that death occurred at* 12:50A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 178	MD	222 East Elm—Caldwell, Idaho	7-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/3/ 67	Kohlerlawn Cemetery	Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-12-1967	Vera Dekan	[signature]	E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2992
Local Reg. No. 166
Reg. Dist. No. 362

Certificate of Death

STATE OF IDAHO

RECEIVED
JUL 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 10 --13th. Avenue South

3. NAME OF DECEASED (Type or Print)
a. (First): MARTINA
b. (Middle): ARRIOLA
c. (Last): MENDIGUREN

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: January 30, 1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Berriatua, Viscaya, Spain
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jose Maria Arriola — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Teresa Alegria — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: Lola D. Garcia — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): CORONARY ARTERY ISCHEMIA

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): BRONCHO PNEUMONIA
DUE TO (c): SEPSIS
DIABETES

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-22-, 19 62 *to* 7-2-, 19 67, *that I last saw the deceased alive on* 7-2-, 19 67, *and that death occurred at* 6:20 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: X Jos Saltzer 454 (Degree or title)
23b. ADDRESS: 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED: 7-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: July 12, 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Tony J. Kroud
LICENSE NO.: E-447

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2993
Local Reg. No. 167
Reg. Dist. No. 362

Certificate of Death

RECEIVED
JUL 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 22yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital-Nampa, Ida.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Midland Manor Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First) Agnes
b. (Middle) Brown
c. (Last) Hartzell

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1967

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 10, 1877
9. AGE (In years last birthday) 89 — If under 1 year: Months 11, Days 23 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Housewife
11. BIRTHPLACE (State or foreign country) Huron Province, Canada
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME David Brown — BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME Sarah Bremner — BIRTHPLACE Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE [signature] — ADDRESS Portland, Ore.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Intestional obstruction, ASHD, Generalized arteriosclerosis — 1wk years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-7, 1967, *to* 7-3, 1967, *that I last saw the deceased alive on* 7-3, 1967, *and that death occurred at* 10:05 *m., from the causes and on the date stated above.*

23a. SIGNATURE Marvin E Blough 730 (Degree or title) MD
23b. ADDRESS 611 So Canyon Nampa Ida
23c. DATE SIGNED 7-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/6/67
24c. NAME OF CEMETERY OR CREMATORY Melba Cemetery
24d. LOCATION (City, town, or county) Melba (State) Idaho

DATE REC'D BY LOCAL REG. July 12, 1967
REGISTRAR'S SIGNATURE Jane Steck
25. EMBALMER William R. Wiseg
LICENSE NO. E-513

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2994
Local Reg. No. 768
Reg. Dist. No. 362

RECEIVED
JUL 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 1119-13 Avenue South

3. NAME OF DECEASED (Type or Print) a. (First) CARL b. (Middle) W. c. (Last) MYERS

4. DATE OF DEATH (Month) July (Day) 3, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 21, 1887
9. AGE (In years last birthday): 79 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. P.F.E. Employee
10b. KIND OF BUSINESS OR INDUSTRY: 06 P.F.E.
11. BIRTHPLACE (State or foreign country): Aurora, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ezra Myers — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Martha J. Jamison — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 18 0046
17. INFORMANT'S OWN SIGNATURE: x Merle D. Myers — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Nephrosclerosis — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease — 10 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 19, 1967, *to* July 3, 1967, *that I last saw the deceased alive on* July 2, 1967, *and that death occurred at* 12:45A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] M.D. 766 (Degree or title)
23b. ADDRESS: 824-17th Ave So, Nampa
23c. DATE SIGNED: 7/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: July 12, 1967
REGISTRAR'S SIGNATURE: Jane Steck
25. EMBALMER: Jerry S. Grounds — LICENSE NO.: E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2995
Local Reg. No. 171
Reg. Dist. No. 362

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

JUL 26 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 303 Locust Street South 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 303 Locust Street South.

3. NAME OF DECEASED (Type or Print)
a. (First) May
b. (Middle) Louise
c. (Last) Frost

4. DATE OF DEATH (Month) (Day) (Year) July 5, 1967.

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH September 20, 1917
9. AGE (In years last birthday) 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Chicago Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Adolph Geigel — BIRTHPLACE Wisconsin
14. MOTHER'S MAIDEN NAME Lillian Witt — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 351 05 2467
17. INFORMANT'S OWN SIGNATURE C. Frost — ADDRESS Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

345X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple Sclerosis — yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-15, 1967, *to* 7-5, 1967, *that I last saw the deceased alive on* 7-5, 1967, *and that death occurred at* 5:20P. *m., from the causes and on the date stated above.*

23a. SIGNATURE Gerald E Weache 559 (Degree or title) MD
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 7-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE July 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Waldhiem Cemetery
24d. LOCATION (City, town, or county) Chicago (State) Illinois

DATE REC'D BY LOCAL REG. July 22, 1967
REGISTRAR'S SIGNATURE Jane Steck
25. EMBALMER William R. Wise Jr.
LICENSE NO. E-513
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2996
Local Reg. No. 161
Reg. Dist. No. 362

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 CANYON 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
c. LENGTH OF STAY (in this place) P.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 142 CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 401 STANFORD

3. NAME OF DECEASED (Type or Print)
a. (First) WALTER
b. (Middle) LEON
c. (Last) EARLEY

4. DATE OF DEATH (Month) (Day) (Year) JULY 6, 1967

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3
8. DATE OF BIRTH FEB. 18, 1893
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CBM 05
10b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY
11. BIRTHPLACE (State or foreign country) KEWANEE, ILLINOIS
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HOWARD EARLEY — BIRTHPLACE IOWA
14. MOTHER'S MAIDEN NAME HATTIE ADAMS — BIRTHPLACE MAINE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES — (If yes, give war or dates of service) WWI & WWII 4 242X
16. SOCIAL SECURITY NO. 565-03-6446
17. INFORMANT'S OWN SIGNATURE Magdaleine Earley — ADDRESS NAMPA, IDAHO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Angioneurotic Edema — INTERVAL BETWEEN ONSET AND DEATH 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Prostate — 8 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-26-, 1967, *to* 7-6-, 1967, *that I last saw the deceased alive on* 7-6-, 1967, *and that death occurred at* 12:03 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Richard C. Troyer M.D. 666 (Degree or title)
23b. ADDRESS NAMPA, IDAHO
23c. DATE SIGNED 7-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 7-7-67
24c. NAME OF CEMETERY OR CREMATORY KOHLERLAWN CEMETERY
24d. LOCATION (City, town, or county) NAMPA, IDAHO (State)

DATE REC'D BY LOCAL REG. July 8, 1967
REGISTRAR'S SIGNATURE Jane Steck
25. EMBALMER M. B. Shepherd — LICENSE NO. 473

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHEPHERD MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 2997
Local Reg. No. 169
Reg. Dist. No. 362

Certificate of Death

RECEIVED
JUL 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Manor Nursing Home 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 1803 3rd. St. N. Nampa

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) JEFFERSON
c. (Last) SHADDY

4. DATE OF DEATH (Month) 7 (Day) 6 (Year) 67

5. SEX M
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Oct. 14, 1880
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY retired
11. BIRTHPLACE (State or foreign country) Grove Springs, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Benton Shaddy — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Rachel Mahaley Randolph — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-60-3913T
17. INFORMANT'S OWN SIGNATURE Muriel L. Shaddy — ADDRESS

18. CAUSE OF DEATH 4341
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Emphysema, Chronic Nephritis, Gastro enteritis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-12, 1946, *to* 7-6-, 1967, *that I last saw the deceased alive on* June 30, 1967, *and that death occurred at* 8:40A. *m., from the causes and on the date stated above.*

23a. SIGNATURE Henry C. Wesche M.D. 560 (Degree or title) 1
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 7-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State) Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG. July 12, 1967
REGISTRAR'S SIGNATURE Jane Steck
25. EMBALMER William R. Wise Jr.
LICENSE NO. E-513

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 27 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2998
Local Reg. No. 172
Reg. Dist. No. 362

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon — JUL 26 1967 — 000
b. CITY OR TOWN Nampa — Bureau of Vital Statistics — c. LENGTH OF STAY in this place
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blvd. Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Blvd. Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edith		Burton	July 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Widowed 2	Aug. 7, 1883.	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
At Home 91		LaCenter, Washington.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Chipman	No Record	No Record	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-36-0895	Mark Burton	Nampa, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Heart — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebrovascular Accident. — 4 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March, 1960 *to* July 8, 1967, *that I last saw the deceased alive on* July 7, 1967 *and that death occurred at* 6 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	[signature]	7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 11, 1967	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 22 1967	[signature]	[signature]	E-496

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record ribbon typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 07 2001

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2999
Local Reg. No. 173
Reg. Dist. No. 363

RECEIVED JUL 26 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 CANYON 000
b. CITY OR TOWN NAMPA
STATE OF STAY (In this place) D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION MERCY HOSPITAL 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 05 CALIFORNIA
b. COUNTY 535 LOS ANGELES
c. CITY OR TOWN RESEDA
d. STREET ADDRESS (If rural, give location) ****

3. NAME OF DECEASED (Type or Print) a. (First) LUTICIA b. (Middle) E. c. (Last) WOOD

4. DATE OF DEATH (Month) JULY (Day) 9 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
FEMALE	WHITE	SEPERATED 4	AUG. 7, 1888	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOME-MAKER 07	AT HOME	NEBRASKA	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
NO RECORD	NO RECORD	NO RECORD	NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		568-46-8571	* Ethel Nichols	EMMETT, IDA.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4280

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-13- *, 19* 67 *to* 7-9- *, 19* 67 *, that I last saw the deceased alive on* 7-9- *, 19* 67 *, and that death occurred at* 1210 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard C. Troyer 666	M.D.	NAMPA, IDAHO	7-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	7-12-67	KOHLER LAWN CEMETERY	NAMPA IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 22 1967	Jane Stuck	M. B. Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3000
Local Reg. No. 15
Reg. Dist. No. 360

RECEIVED
JUL 26 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 2411 College Ave

3. NAME OF DECEASED (Type or Print)
a. (First) Nellie b. (Middle) M. c. (Last) Carpenter

4. DATE OF DEATH (Month) (Day) (Year) July 9, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 27, 1907
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Carney, Nebr.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry W. Keiser — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Edith Pearl — BIRTHPLACE Carney, Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. 519-28-3315
17. INFORMANT'S OWN SIGNATURE Nese Carpenter — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Astrocytoma Brain 1930 — INTERVAL BETWEEN ONSET AND DEATH 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1967, *to* July 9, 1967, *that I last saw the deceased alive on* July 9, 1967, *and that death occurred at* 2:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE M Jensen 258 MD-1 (Degree or title)
23b. ADD Robert H. Jensen, M.D. 222 EAST LOGAN CALDWELL, IDAHO
23c. DATE SIGNED 7-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 12, 1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Memotial Gardens
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. 7-21-67
REGISTRAR'S SIGNATURE Freda G. Hunt, Deputy
25. EMBALMER Merville D. Davis — LICENSE NO. E-399

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 22 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 25 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3001
Local Reg. No. 14
Reg. Dist. No. 360

RECEIVED JUL 20 1967 Vital Statistics Bureau of Health

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wirth Corp 42nd Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141 b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): Box 862

3. NAME OF DECEASED (Type or Print)
a. (First): JULIAN
b. (Middle):
c. (Last): GARZA

4. DATE OF DEATH: (Month) 7 (Day) 10 (Year) 67

5. SEX: M

6. COLOR OR RACE: Mexican

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Child

8. DATE OF BIRTH: May 1, 1964

9. AGE (In years last birthday): 3 — IF UNDER 1 YEAR: Months 2 Days 9 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02

10b. KIND OF BUSINESS OR INDUSTRY: Child

11. BIRTHPLACE (State or foreign country): Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Amador Garza — BIRTHPLACE: Old Mexico

14. MOTHER'S MAIDEN NAME: Sandea Emery — BIRTHPLACE: Detroit, Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X Amador A. Garza — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Body pulverized — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) by falling into a
DUE TO (c) Wood pulverizer

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Wood factory 23
21c. (CITY, TOWN, OR TOWNSHIP): Caldwell 13 (COUNTY): 141 Canyon (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 - 10 - 67 7:30 P. m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ 2
21f. HOW DID INJURY OCCUR?: Fell on a belt conveyor carried into pulverizer

22. *I hereby certify that I attended the deceased from* Inspection only, 19___, to ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wesche 583 (Degree or title): M.D
23b. ADDRESS: Nampa - Idaho
23c. DATE SIGNED: 7-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/12/67
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: 7-18-1967
REGISTRAR'S SIGNATURE: Vera Dakan
25. EMBALMER: Leonard C. Flahiff — LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3002
Local Reg. No. 13
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED
JUL 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakeley Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): 2022 Washington

3. NAME OF DECEASED (Type or Print)
a. (First): LaNore
b. (Middle): Marie
c. (Last): Burke

4. DATE OF DEATH (Month) 7 (Day) 10 (Year) 67

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married /
8. DATE OF BIRTH: Jan. 7, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months 5, Days 3 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookeeper 19
10b. KIND OF BUSINESS OR INDUSTRY: Dairymens Coop.
11. BIRTHPLACE (State or foreign country): York, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edwin E. Burke — BIRTHPLACE: York, Nebraska
14. MOTHER'S MAIDEN NAME: Ona Bedson — BIRTHPLACE: Lincoln, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-22-4309
17. INFORMANT'S OWN SIGNATURE: x Ona E Burke — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 170X Carcinoma of the breast with — INTERVAL BETWEEN ONSET AND DEATH: 19 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Extensive metastasis generalized
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1955, *to* July, 1967, *that I last saw the deceased alive on* 7-8, 1967, *and that death occurred at* 630P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 280 MD 1
23b. ADDRESS: 1819 Ellis St Caldwell Idaho
23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial /
24b. DATE: 7/13/67
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: 7-18-1967
REGISTRAR'S SIGNATURE: Vera Dakan
25. EMBALMER: Lucy M. Flahiff — LICENSE NO. E393
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

OCT 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3003
Local Reg. No. 174
Reg. Dist. No. 362

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 26 1967

1. PLACE OF DEATH
a. COUNTY Canyon 142 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (If not in place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blvd. Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 303-15th Ave. North

3. NAME OF DECEASED (Type or Print)
a. (First) Mahalia (May)
b. (Middle)
c. (Last) Ward

4. DATE OF DEATH (Month) July (Day) 11, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 22, 1893
9. AGE (In years on birthday) 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George A. Evans — BIRTHPLACE No record
14. MOTHER'S MAIDEN NAME Nettie J. Hooper — BIRTHPLACE No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-62-5200
17. INFORMANT'S OWN SIGNATURE X [signature] — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalize Hypertensive
DUE TO (c) ASHD — 5 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1960 *to* July, 1967, *that I last saw the deceased alive on* July 7, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 115 (Degree or title)
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) Canyon county (State) Idaho

DATE REC'D BY LOCAL REG. July 22, 1967
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER [signature] — LICENSE NO. E-496
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3004
Local Reg. No. 175
Reg. Dist. No. 362

BIRTH NO.

JUL 26 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: 142 Canyon 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 142

b. COUNTY: Canyon

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa

d. STREET ADDRESS (If rural, give location): 124 Owyhee St.

3. NAME OF DECEASED (Type or Print)

a. (First): SHIRLEY

b. (Middle): S.

c. (Last): HARMON

4. DATE OF DEATH (Month) (Day) (Year): July 11, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: July 12, 1883

9. AGE (In years last birthday): 84

If under 1 year: Months / Days

If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Jasper, Indiana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Morgan

BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: no record

BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 314 26 2587A

17. INFORMANT'S OWN SIGNATURE: X L. C. Harmon

ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebrovasc Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): ASHD

years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 *, 19*59*, to* July *, 19*67*, that I last saw the deceased alive on* June *, 19*29*, and that death occurred at* 6:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Graydon O. Cross 115 (Degree or title)

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Sh Removal

24b. DATE: July 11,

24c. NAME OF CEMETERY OR CREMATORY: Cane Creek Cemetery

24d. LOCATION (City, town, or county) (State): Cane Creek Indiana

DATE REC'D BY LOCAL REG.: July 22 1967

REGISTRAR'S SIGNATURE: Jane Steck

25. EMBALMER: Terry S. Krouch

LICENSE NO.: E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 26 1967

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3005
Local Reg. No. 12
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JUL 20 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY IN (this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hos. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 370
b. COUNTY: Owyhee 304
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print): a. (First) Lena b. (Middle) P. c. (Last) Proud

4. DATE OF DEATH: (Month) July (Day) 12, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Jan 16, 1889

9. AGE (In years last birthday): 78 IF UNDER 1 YEAR Months: 5 Days: 26 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Napa, California

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Henry Wilson BIRTHPLACE: Joliet, Ill.

14. MOTHER'S MAIDEN NAME: Rachel Sullivan BIRTHPLACE: Buffalo Grove, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE ADDRESS: x Mrs. Boyd Nash

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 5705 Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Intra abdominal adhesions — 1 day
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Degeneration Heart disease — yrs

19a. DATE OF OPERATION: 7-12-67

19b. MAJOR FINDINGS OF OPERATION: Gangrenous degeneration of ileum

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jul 8, 19 67, *to* Jul 12, 19 67, *that I last saw the deceased alive on* Jul 12, 19 67, *and that death occurred at* 2:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] MD (Degree or title)

23b. ADDRESS: Caldwell Ida

23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 14, 1967

24c. NAME OF CEMETERY OR CREMATORY: Marsing-Homedale

24d. LOCATION (City, town, or county) (State): Homedale, Idaho

DATE REC'D BY LOCAL REG.: 7-18-1967

REGISTRAR'S SIGNATURE: Vera Dakan

25. EMBALMER: Leonard C. Flaniff LICENSE NO.: E-481

FIRM NAME: Homedale's Flaniff Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3006
Local Reg. No. 2
Reg. Dist. No. 360

BIRTH NO.

AUG - 1 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 14 Canyon 102
b. CITY OR TOWN Caldwell
c. LENGTH OF STAY (in this place) 1½ yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blakleys Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 14
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1320 Arthur St.

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) William c. (Last) Pilkenton

4. DATE OF DEATH (Month) (Day) (Year) July 12, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Jan. 15, 1880

9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 78

10b. KIND OF BUSINESS OR INDUSTRY Ditch Rider

11. BIRTHPLACE (State or foreign country) Verona, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Pilkenton BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWI 3

16. SOCIAL SECURITY NO. 500-01-5979

17. INFORMANT'S OWN SIGNATURE + Dovie D Pilkenton ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4477

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhagic cystitis — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Post hemiplegic debility — 1 year

DUE TO (c) Hypertensive vascular disease — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/7/56, 19__, *to* 7/12/67, 19__, *that I last saw the deceased alive on* July 12, 19 67, *and that death occurred at* 10:30a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 225 M.D. / **23b. ADDRESS** 1201 S. Kimball, Caldwell, Idaho **23c. DATE SIGNED** 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** July 17, 1967 **24c. NAME OF CEMETERY OR CREMATORY** Canyon Hill Cemetery **24d. LOCATION** (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. 7-28-1967 **REGISTRAR'S SIGNATURE** Vera Dakan **25. EMBALMER** Rodney E. Dakan **LICENSE NO.** E-528

FIRM NAME: Peckham-Dakan Chapel Caldwell, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3007
Local Reg. No. 177
Reg. Dist. No. 362

RECEIVED JUL 26 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 CANYON 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
LENGTH OF STAY (in this place) 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 142 b. COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 507 7th AVE. SOUTH

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PEARL	M.	LATHAM	JULY 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	DIVORCED 7	APRIL 10, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TELEGRAPH OPERATOR 70	U.P. RAIL ROAD	BAYFIELD, WISCONSIN	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOHN C. WILKINSON	NO RECORD	ANNA M. NO RECORD	NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		519-07-3896	[signature]	NAMPA, IDA.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute entero colitis — INTERVAL BETWEEN ONSET AND DEATH 12h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arteriosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 13, 1967, *to* July 13, 1967, *that I last saw the deceased alive on* July 13, 1967, *and that death occurred at* 10:30 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marion E Blough 730 MD	NAMPA, IDAHO	7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	7-17-67	CLOVERDALE CEMETERY	ADA COUNTY IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 22, 1967	Jane Stuck	[signature]	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

2 — DUTIES:

SEP 26 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED JUL 26 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3008
Local Reg. No. 176
Reg. Dist. No. 362

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 516 16th Ave South

3. NAME OF DECEASED (Type or Print): a. (First) Marjorie b. (Middle) L. c. (Last) Hibnes

4. DATE OF DEATH (Month) (Day) (Year): July 13, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 20, 1920

9. AGE (In years last birthday): 47 — If UNDER 1 YEAR: Months / Days — If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: J. R. Simplot Co.

11. BIRTHPLACE (State or foreign country): Burwell, Nebr.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Rev. Ben Harris — BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Mabel Clark — BIRTHPLACE: Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: John Hibnes Sr. — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BILATERAL SEROUS CYSTADENO CARCINOMA OF OVARIES — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) WIDE SPREAD METASTASIS

DUE TO (c) BOWEL OBSTRUCION

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: 7-1-67

19b. MAJOR FINDINGS OF OPERATION: CECOSTOMY TO RELIEVE BOWEL OBSTRUCTION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 5-13- *, 19* 67 *, to* 7- 13- *, 1967, that I last saw the deceased alive on* 7-13- *, 19* 67 *, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Glen W. Russell MD

23b. ADDRESS: 619 So. Canyon, Nampa, Idaho

23c. DATE SIGNED: 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 17, 1967

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: July 22, 1967

REGISTRAR'S SIGNATURE: Jane Stuck

25. EMBALMER: Merville D. Davis — LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 27 1967

FEB 24 1986

JUN · 1993

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to certify the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3009
Local Reg. No. 16
Reg. Dist. No. 360

RECEIVED JUL 26 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 14 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CALDWELL
LENGTH OF STAY (in this place): 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CALDWELL MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 16 b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL NAMPA
d. STREET ADDRESS (If rural, give location): ROUTE 2

3. NAME OF DECEASED (Type or Print): a. (First) ETHEL b. (Middle) M. 051 c. (Last) BECKER

4. DATE OF DEATH (Month) (Day) (Year): JULY 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	WIDOWED 2	SEPT. 2, 1889	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOME-MAKER 01	AT HOME	SCRIBNER, NEBRASKA	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
SAM JONES	NO RECORD	MARGARET HOUSTON	NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		519-60-9188	Mrs. Oswald H. Scholte	NAMPA

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*	INTERVAL BETWEEN ONSET AND DEATH
(a)	Chronic myocardial degeneration	years
DUE TO (b)	Coronary Sclerosis	years
DUE TO (c)		

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 11, 1967, *to* July 14, 1967, *that I last saw the deceased alive on* July 14, 1967, *and that death occurred at* 8:15P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
570 MD	CALDWELL, IDAHO	7-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL 2	7-15-67	PEBBLE CEMETERY	DODGE COUNTY, NEBRASKA

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-21-67	Irene G. Hunt Deputy	W. B. Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3010
Local Reg. No. 19
Reg. Dist. No. 360

RECEIVED JUL 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141 000
b. CITY OR TOWN Caldwell (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5 th. & Joliet St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 370 b. COUNTY Owyhee
c. CITY OR TOWN Homedale (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location) City

3. NAME OF DECEASED (Type or Print) a. (First) Judson b. (Middle) Irving c. (Last) Taggart

4. DATE OF DEATH (Month) (Day) (Year) July 14, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 27

8. DATE OF BIRTH Oct. 12, 1925

9. AGE (In years last birthday) 41 | IF UNDER 1 YEAR Months 9 Days 2 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman - Retired 27

10b. KIND OF BUSINESS OR INDUSTRY Selling

11. BIRTHPLACE (State or foreign country) American Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Durland Orrville Taggart BIRTHPLACE Indiana

14. MOTHER'S MAIDEN NAME Etna Green, Alice I. Wheeler BIRTHPLACE Caldwell, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII & Korean

16. SOCIAL SECURITY NO. 519-09-0967

17. INFORMANT'S OWN SIGNATURE x Mrs. Margaret Cromwell ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Inspection only, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE Henry C. Wesche 583 (Degree or title) M.D. Coroner 4

23b. ADDRESS Nampa Idaho

23c. DATE SIGNED 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 18, 1967

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. 7-25-1967

REGISTRAR'S SIGNATURE Vera Dakan

25. EMBALMER Howard C. Flahiff

LICENSE NO. E- 481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 9 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 26 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3011
Local Reg. No. 177
Reg. Dist. No. 362

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 500
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa | LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142 b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 315-11th Ave. South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	Arthur	Finch	July 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 11, 1873	93				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Minister 18	Ministerial	Port Rowan, Canada	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Finch	No record	Elizabeth Williams	No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		D A Finch	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic
DUE TO (c) Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Senility

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 2, 1967 *to* July 16, 1967, *that I last saw the deceased alive on* July 16, 1967, *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J R Mangum MD 322	Nampa, Idaho	7/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 18, 1967	Riverside Cemetery	Payette County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 22, 1967	Jane Finch	Richard W Messenbrink	E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 8 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 26 1967 Bureau of Vital Statistics

State File No. 3012
Local Reg. No. 178
Reg. Dist. No. 362

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 328 Caldwell Blvd.

3. NAME OF DECEASED (Type or Print): a. (First) ADOLPH; b. (Middle); c. (Last) LAUTERBACH

4. DATE OF DEATH: (Month) July (Day) 16, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: July 9, 1897

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): P.F.E. CARMAN 10

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Dillon Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael Lauterbach
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Marie
BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 700-09-3287

17. INFORMANT'S OWN SIGNATURE: P.C. Peterson
ADDRESS: Dillon, Montana

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pneumonia — Days
DUE TO (c) Malignancy Lymphosarcoma & Prostatic Hypertrophy — Days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐ X

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April, 1967, *to* July, 1967, *that I last saw the deceased alive on* July 16, 1967, *and that death occurred at* 9:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 115 (Degree or title)
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Dillon Cemetery
24d. LOCATION (City, town, or county) (State): Dillon Montana

DATE REC'D BY LOCAL REG.: July 22 1967
REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Richard W. Meenbrink
LICENSE NO.: E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
FORM DH-61021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 2 1967

AUG 27 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3013
Local Reg. No. 181
Reg. Dist. No. 362

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): R# 3

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): RAY
c. (Last): PATTERSON

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 24, 1901
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Realtor 04
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Gower Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John L. Patterson — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Jennie Buck — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 700-10-6532
17. INFORMANT'S OWN SIGNATURE: Carolyn Patterson — ADDRESS: Stone, Nampa

18. CAUSE OF DEATH 203X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH: 6 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-9-67, *19*__, *to* 7-17-, *19* 67, *that I last saw the deceased alive on* 7-17-, *19* 67, *and that death occurred at* 4:00P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert Elday MD 217 1
23b. ADDRESS: 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED: 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 19, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Ada County Idaho

DATE REC'D BY LOCAL REG.: July 29, 1967
REGISTRAR'S SIGNATURE: June L. Steck
25. EMBALMER: Richard W. Mesenbrink — LICENSE NO.: E-487

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3014
Local Reg. No. 180
Reg. Dist. No. 362

RECEIVED
JUL 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give V.): Nampa
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1403-10 Ave. south

3. NAME OF DECEASED (Type or Print): a. (First) Elinor b. (Middle) H. c. (Last) HOWARD

4. DATE OF DEATH: (Month) July (Day) 17, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: January 12, 1902

9. AGE (In years last birthday): 65
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Springfield Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edward S. Finch
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Brella Gabrielle Sherwood
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Mary E. Mesterell
ADDRESS: Tulsa, Okla.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4209

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Ht. Disease — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (c) Senility — INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July 1, 1967 *to* July 17, 1967, *that I last saw the deceased alive on* July 17, 1967, *and that death occurred at* 3:15 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: R. Branzenburg 322 (Degree or title)
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 7/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE REC'D BY LOCAL REG.: July 26, 1967
REGISTRAR'S SIGNATURE: Jane L. Steele
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 21 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended July 31, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3015
Local Reg. No. 18
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakeley Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142 b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa, Idaho
d. STREET ADDRESS (If rural, give location): 1111 - 6th St. South

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Murial	E.	Jacobs	July 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	W	Married 3	Feb. 1, 1896	71	5	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 08
10b. KIND OF BUSINESS OR INDUSTRY: Dept. Interior
11. BIRTHPLACE (State or foreign country): Fort Bidwell, Calif.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oliver W. Jacobs — BIRTHPLACE: Lake City, Calif.
14. MOTHER'S MAIDEN NAME: Ursula Messner — BIRTHPLACE: Fort Bidwell, Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-58-0142
17. INFORMANT'S OWN SIGNATURE: Hannah Jacobs — ADDRESS: 1111 - 6th St. So., Nampa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 491X Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bladder Tumor — 2 yrs.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 16 Jul, 19 67, *to* 17 Jul, 19 67, *that I last saw the deceased alive on* 16 Jul, 19 67, *and that death occurred at* 1:55A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Krause, M.D.	295	Caldwell, Idaho	19 Jul 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7-19-67	IOOF Cemetery	Lakeview, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-25-1967	Vera Dakan	Lucy M. Flahiff	E393

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flahiff Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

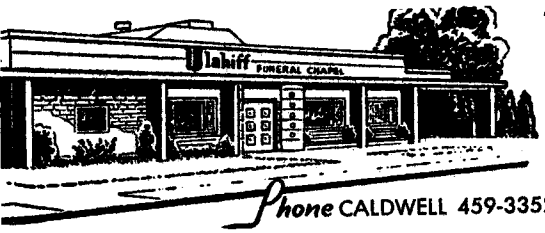

Flahiff
FUNERAL CHAPEL
624 CLEVELAND BOULEVARD
CHARLES B. FLAHIFF LUCY M. FLAHIFF
LEONARD C. FLAHIFF

July 29, 1967

AFFIDAVIT

The Social Security No. (519-55-0142) Which appears on the death certificate of Muriel E. Jacobs is incorrect. The number should be 519-58-0142 to correct the death certificate.

Sign by Hannah Jacobs.

Wife of the deceased

Leonard C. Flahiff

Funeral Director

State of Idaho, County of CANYON. On this 31ST day of July in the year 1961, before me Gordon L. Buck a Notary Public in and for said State personally appeared Leonard C. Flahiff

known to me to be the person whose name IS subscribed to the within instrument, and acknowledged to me that ____ he ____ executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal, the day and year in this certificate first above written.

Gordon L. Buck
Notary Public for the State of Idaho
Residing at Caldwell, Idaho

Flahiff
FUNERAL CHAPEL
624 CLEVELAND BOULEVARD
CHARLES B. FLAHIFF JOHN M. FLAHIFF
LEONARD C. FLAHIFF

Home CALDWELL 419-3352

July 29, 1967

[illegible]

The Social Security No. (519-55-0148) which appears on the death certificate of [illegible] is incorrect. The number should be 519-78-0148 to correct the death certificate.

Sign by [illegible]

[illegible]

Funeral Director

State of Idaho, County of _____. On this _____ day of _____ in the year 19__, before me _____ Notary Public in and for said State personally appeared _____

known to me to be the person _____ whose name _____ subscribed to the within instrument, and acknowledged to me that ____ he ____ executed the same.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my seal, the day and year in this certificate first above written.

Notary Public for the State of Idaho
Residing at _____, Idaho

Flahiff
FUNERAL CHAPEL
624 CLEVELAND BOULEVARD
CHARLES B. FLAHIFF LUCY M. FLAHIFF
LEONARD C. FLAHIFF
CALDWELL, IDAHO

August 9, 1967 Affidavit

The spelling of the name of Muriel E. Jacobs which appears on the death certificate is incorrect. The name should be spelled Murial E. Jacobs to correct the death certificate.

Signed by Hannah Jacobs.

Wife of the deceased

Lucy M. Flahiff

Funeral Director

State of Idaho, County of Canyon. On this 9 day of Aug in the year 1967, before me Chas. L. Shaffer, a Notary Public in and for said State personally appeared Hannah Jacobs, known to me to be the person whose name is subscribed to the within instrument, and acknowledged to me that she executed the same.

In Witness Whereof, I have hereunto set my hand and affixed my seal, the day and year in this certificate first above written.

Chas. L. Shaffer

Notary Public for the State of Idaho

Residing at Caldwell, Idaho

Flahiff
FUNERAL CHAPEL
[illegible] CLEVELAND BOULEVARD
CHARLES B. FLAHIFF LUCY M. FLAHIFF
LEONARD C. FLAHIFF
CALDWELL, IDAHO

August 9, 1987 Affidavit
The spelling of the name of Muriel E. Jacobs which appears on the death certificate is incorrect. The name should be spelled Muriel E. Jacobs to correct the death certificate.

Signed by _____

Wife of the deceased

_____
Funeral Director

State of Idaho, County of _____. On this _____ day of _____ in the year 19__, before _____, known to me to be the person _____ whose name _____ subscribed to the within instrument, and acknowledged to me that he executed the same.

In Witness Whereof, I have hereunto set my hand and affixed my seal, the day and year in this certificate first above written.

_____
Notary Public for the State of Idaho

Residing at _____, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 36-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 18
Reg. Dist. No. 360

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakeley Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa, Idaho
d. STREET ADDRESS (If rural, give location): 1111n 6th St. South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MURIAL	E	JACOBS	7	17	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married	Feb. 1, 1896	71	5	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired	Dept. of Interior	Fort Bidwell, Calif	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oliver W. Jacobs	Lake City, Calif	Ursula Messner	Fort Bidwell, Calf,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	519-55-0142	Hannah Jacobs	1111 6th St Nampa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bladder Tumor — 2 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 16 Jul, 1967, *to* 17 Jul, 1967, *that I last saw the deceased alive on* 16 Jul, 1967, *and that death occurred at* 1:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E. Krauss	M.D.	Caldwell, Idaho	19 Jul 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	7/19/67	IOOF Cemetery	Lakeview, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-25-1967	Vera Dakan	Lucy M. Flahiff	E393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUL 27 1967

AUG 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3016
Local Reg. No. 4
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 2 Hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 370
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print)
a. (First): Antonio
b. (Middle): G. (Tony)
c. (Last): Basabe

4. DATE OF DEATH (Month) (Day) (Year): July 19, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 10, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months 0 Days 9 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner & Operator 23
10b. KIND OF BUSINESS OR INDUSTRY: Night Club
11. BIRTHPLACE (State or foreign country): Cortezubi, Vizcaya, Spain
12. CITIZEN OF WHAT COUNTRY? Spain

13. FATHER'S NAME: Anastario Basabe — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Victoria Guisasola — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-20-2610
17. INFORMANT'S OWN SIGNATURE: Dominga (Ill) Basabe — ADDRESS

18. CAUSE OF DEATH 5020
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic obstructive pulmonary emphysema about 7½ yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) asthmatic bronchitis
DUE TO (c) Rt ventricular dilatation and hypertrophy

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Left ventricular hypertrophy

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-7-61, 19__, *to* 7-19-67, 19__, *that I last saw the deceased alive on* 7-19-67, 19__, *and that death occurred at* 3:55A. *m., from the causes and on the date stated above.*

23a. SIGNATURE: W S Hubler MD 250 (Degree or title)
23b. ADDRESS: 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED: 7-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Aug. 4, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Elahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Homedale's Elahiff Chapel

DUTIES:

AUG 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3017
Local Reg. No. 23
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 016 b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle
d. STREET ADDRESS (If rural, give location): Rt. # 1, Box 184

3. NAME OF DECEASED (Type or Print): a. (First) Anton b. (Middle) V. c. (Last) Carlson

4. DATE OF DEATH (Month) (Day) (Year): July 20, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 27, 1886
9. AGE (In years last birthday): 81 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Christine Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 520-14-1287
17. INFORMANT'S OWN SIGNATURE: Eunice R Carlson ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

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I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Primary site undetermined.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-14-67, 19___, *to* 7-20-67, 19___, *that I last saw the deceased alive on* 7-20-67, 19___, *and that death occurred at* 12:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Kyle Dorsa, M. D. 505 (Degree or title)
23b. ADDRESS: 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED: 7-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: July 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Memorial
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 7-29-1967
REGISTRAR'S SIGNATURE: Vera Dakan
25. EMBALMER: Merville D Davis
LICENSE NO.: E-399
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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RECEIVED

JUL 27 1967

Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3018

Local Reg. No. 17

Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 338 b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale, Idaho
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) 051 c. (Last) CEGNAR

4. DATE OF DEATH (Month) 7 (Day) 20 (Year) 67

5. SEX F

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH April 25, 1880

9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months 2 Days 25 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Skofja Loka, Yugoslavia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Matt Kalan, Yugoslavia

14. MOTHER'S MAIDEN NAME Maria Unknown BIRTHPLACE Yugoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 519-56-9271

17. INFORMANT'S OWN SIGNATURE X Mrs. Mary Jesenko ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis 3347

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1966, to Jul 20, 1967, that I last saw the deceased alive on Jul 20, 1967, and that death occurred at 7:20 a.m., from the causes and on the date stated above.

23a. SIGNATURE 510 Md (Degree or title)

23b. ADDRESS Caldwell Ida

23c. DATE SIGNED 7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/24/67

24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary

24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. 7-25-1967

REGISTRAR'S SIGNATURE Vera Dakan

25. EMBALMER

LICENSE NO. E-481

FIRM NAME Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 17 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3019
Local Reg. No.
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): I.O.O.F. Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 16
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): I.O.O.F. Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ira	E.	Jennings	July 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	April 27, 1881	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Ft. Worth, Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-09-5682A	Glenna M. Krohn	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	4201 Acute Coronary	5 Months
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	H C V D	1yr
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 1966, *to* July, 1967, *that I last saw the deceased alive on* July 20, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Neil E. Reynolds 437 MD	Caldwell Idaho	8/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 26, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 4, 1967	Mrs. Martina Walmsley	Kenneth E. Spence	E-395

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

AUG - 1 1967

Certificate of Death

STATE OF IDAHO

State File No. 3020
Local Reg. No. 20
Reg. Dist. No. 360

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Edith b. (Middle) E. c. (Last) Mason

4. DATE OF DEATH (Month) (Day) (Year) July 22, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Jan. 23, 1889
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Caldwell, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Jobe — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE X Betty E Kinley — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9039

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRO-VASCULAR ACCIDENT

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) INTERTROCHANTERIC FRACTURE (R) HIP

DUE TO (c) DIABETES MELLITUS

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 00
21c. (CITY, TOWN, OR TOWNSHIP) CALDWELL 13 (COUNTY) CANYON 141 (STATE) IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7 13 67 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? FALL ON (R) HIP

22. *I hereby certify that I attended the deceased from* 7-13 2, 1967, *to* 7-22, 1967, *that I last saw the deceased alive on* 7-22, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE W. Gunnechtel 759 (Degree or title) M.D. 1
23b. ADDRESS 206 E-ELM ST.
23c. DATE SIGNED 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE July 25, 1967
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. 7-28-1967
REGISTRAR'S SIGNATURE Vera Dakan
25. EMBALMER Rodney W Dakan
LICENSE NO. E-508

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or ~~conditions~~ resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3021
Local Reg. No. 182
Reg. Dist. No. 362

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 1 1967 Bureau of V. Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 133 Davis 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 133 Davis

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): WILLIAM
c. (Last): PATTERSON

4. DATE OF DEATH (Month) (Day) (Year): July 23, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 5, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.P. R.R. Inspector 10
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Savannah, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William T. Patterson — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Emma Elzina Couch — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs. James W. Patterson — ADDRESS: Nampa, Id

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cerebral Vasc. Disease — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Arteriosclerotic Heart Disease — 3 yrs

334X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-1-66, 19__, *to* 7-23-, 19 67, *that I last saw the deceased alive on* 7-23-, 19 67, *and that death occurred at* 10:00P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 217 MD
23b. ADDRESS: 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED: 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mausoleum
24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE REC'D BY LOCAL REG.: July 29 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature] — LICENSE NO.: E-496
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 14 1983

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG - 1 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3022
Local Reg. No. 22
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 27 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place) 3 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blakely Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 140 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parma
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Sara	Belle	Miller	July	23	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	April 14 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 01	Home	Warren County Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Martin	UNK	Elizabeth Gamble	UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-62-0336-T	Helen L. Wilson	Parma

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CVA — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis — 20 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Recent cholecystectomy — 2 months
Previous left hemiplegia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	cholelithiasis + cholecystitis	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May, 1967, *to* 23 July, 1967, *that I last saw the deceased alive on* 23 July, 1967, *and that death occurred at* 1:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald D. Price 429	M.D.	Caldwell Ida	7/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-27-1967	Parma	Parma Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
7-29-1967	Vera Dakan	Richard D. Grant	E-500

Peckham-Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

State File No. 3023
Local Reg. No. 1
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 15 MO.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1523 7th ST. NORTH 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 142
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 1523 7th STREET NORTH

3. NAME OF DECEASED (Type or Print)
a. (First): ORVILLE
b. (Middle): V.
c. (Last): ROGERS

4. DATE OF DEATH (Month) (Day) (Year): JULY 24, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: DEC. 19, 1903
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PRESSMAN 21
10b. KIND OF BUSINESS OR INDUSTRY: HYDRAULIC
11. BIRTHPLACE (State or foreign country): LURAY, KANSAS
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN N. ROGERS — BIRTHPLACE: KANSAS
14. MOTHER'S MAIDEN NAME: TRESSIA H. HOOPER — BIRTHPLACE: NORTH CAROLINA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 512-07-0812
17. INFORMANT'S OWN SIGNATURE: X Mildred E. Rogers — ADDRESS: NAMPA

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arterio sclerotic C.V. disease — yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Congestive Heart failure

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-10-, 1967, *to* 7-24-, 1967, *that I last saw the deceased alive on* 7-23-, 1967, *and that death occurred at* 3:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Gerald C Hencke — 559 (Degree or title): MD 1
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 7-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3
24b. DATE: 7-25-67
24c. NAME OF CEMETERY OR CREMATORY: WOODLAKE CEMETERY
24d. LOCATION (City, town, or county) (State): WOODLAKE, CALIFORNIA

DATE REC'D BY LOCAL REG.: Aug. 1, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd — LICENSE NO. 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

State File No. 3024
Local Reg. No. 2
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1308-4th. St. South

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): ALICE
c. (Last): DILLER

4. DATE OF DEATH: July 24, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: June 19, 1885

9. AGE (In years last birthday): 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Rock Ridge, Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: W.T. Harrison
BIRTHPLACE: Virginia

14. MOTHER'S MAIDEN NAME: Melissa C. Gilmore
BIRTHPLACE: West Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: John F Alsip Jr
ADDRESS: Nampa Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4288

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart disease.
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Acute gastro enteritis

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-30, 1966, *to* 7-24, 1967, *that I last saw the deceased alive on* 7-24, 1967, *and that death occurred at* 1:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Warren E Blough (Degree or title): MD
23b. ADDRESS: 1619 So Canyon Nampa
23c. DATE SIGNED: 7-28-

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: July 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Aurora Cemetery
24d. LOCATION (City, town, or county) (State): Aurora Oregon

DATE REC'D BY LOCAL REG.: Aug 2 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature] LICENSE NO.: E-496
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

J.P. Finck

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3025
Local Reg. No. 12
Reg. Dist. No. 360

BIRTH NO.

AUG 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 441
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): HANNAH
b. (Middle): REBECCA
c. (Last): CHAPMAN

4. DATE OF DEATH (Month) 7 (Day) 25 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: February 3, 1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Cleveland, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Rawley Ransom — BIRTHPLACE: Washington County Utah
14. MOTHER'S MAIDEN NAME: Hannah Elizabeth Ames — BIRTHPLACE: Cache County, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Howard Chapman — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac standstill due to congestive failure
ANTECEDENT CAUSES — DUE TO (b) due to myocardial ischemia - coronary sclerosis - hypertension
DUE TO (c) diabetes mellitus

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death

INTERVAL BETWEEN ONSET AND DEATH: 3 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Fractured Pt hip.
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-22, 1967 *to* 7-25, 1967, *that I last saw the deceased alive on* 7-25, 1967, *and that death occurred at* 8 *m., from the causes and on the date stated above.*

23a. SIGNATURE: J. Finck 166 (Degree or title) — **23b. ADDRESS**: Caldwell Ida — **23c. DATE SIGNED**: 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-27-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Aug. 8, 1967
REGISTRAR'S SIGNATURE: Miss Martina Walmsley
25. EMBALMER: Conway Grant — LICENSE NO. E478
FIRM NAME: RENYEA CHAPEL, BOISE, IDAHO

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3026
Local Reg. No. 7
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142 b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 108 Winther Boulevard

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EFFIE	THOMAS	THOMSON	July 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widow 2	30 Nov 1892	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Teton City, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Edward Thomas	Brigham City, Utah	Mary Jane Maughan	Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	None	Dean Thomson	108 Winther Blvd Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 334X Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis
DUE TO (c) Chronic Nephritis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hydronephrosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19 65, *to* July 25, 19 67, *that I last saw the deceased alive on* July 25, 19 67, *and that death occurred at* 10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H B Marcusen MD 326	NAMPA, IDAHO	8-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	28 July 67	Teton-Newdale Cemetery	Sugar City, R.F.D. 1, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 7 1967	Mrs. Martina Walmsley	W. B. Shepherd	473

FIRM NAME: HANSEN MEMORIAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3027
Local Reg. No. 22
Reg. Dist. No. 360

RECEIVED
AUG 15 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 14/Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. Memorial Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 14/ b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 622 So. 9th St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	James	Franklin	Brown	July 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct. 28, 1890	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04		Lebanon, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George F. Brown	Illinois	Emma Leonard	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-16-5338A	E. Carol Blakley	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary occlusion--old and recent

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-6-67, 19___, to 7-26-67, 19___, *that I last saw the deceased alive on* 7-24-67, 19___, *and that death occurred at* About 3, P. M. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wyle Stone, M.D. 505	/	222 East Elm--Caldwell, Idaho	8-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 31, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 14 1967	Mrs. Martin Walmsley	Merville D. Davis	E-399

FIRM NAME: Peckham-Dakan Funeral Chapel, Caldwell

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3028
Local Reg. No. 3
Reg. Dist. No. 360

BIRTH NO.

AUG 8 - 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: 142 Canyon 500

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): R# 4-Nampa -Bowmont Road

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bowmont Rd.-R# 4 Nampa 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 142

b. COUNTY: Canyon

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa

d. STREET ADDRESS (If rural, give location): Checola Drive

3. NAME OF DECEASED (Type or Print)

a. (First): Roger

b. (Middle): Dale

c. (Last): Yorgason

4. DATE OF DEATH (Month) (Day) (Year): July 27, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single 1

8. DATE OF BIRTH: Sept. 12, 1950

9. AGE (In years last birthday): 16

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: High School

11. BIRTHPLACE (State or foreign country): Nampa, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Eldon Yorgason

BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Norma Johnson

BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-62-7861

17. INFORMANT'S OWN SIGNATURE: Eldon J Yorgason

ADDRESS:

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Head Injury

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): auto accident

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Canyon 140 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 27 - 1967 11 P. m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Missed a curve and car ran over a steep cliff

22. *I hereby certify that I attended the deceased from* 2 Inspection only *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* approx. 11:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesche M.D. 583 Coroner 4

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1

24b. DATE: July 31, 1967

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorail Park

24d. LOCATION (City, town, or county) (State): Ada County Idaho

DATE REC'D BY LOCAL REG.: Aug. 3, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Richard W. Mesenbrink

LICENSE NO.: E-487

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

AUG 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 24 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3029
Local Reg. No. 5
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141 407
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (in this place) 7 Hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hos. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Huston Farms Labor Camp Caldwell
d. STREET ADDRESS (If rural, give location) Rural Rt. #6

3. NAME OF DECEASED (Type or Print) a. (First) Edelmira b. (Middle) c. (Last) Garza

4. DATE OF DEATH (Month) (Day) (Year) July 28, 1967

5. SEX Female
6. COLOR OR RACE Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 27, 1901
9. AGE (In years last birthday) 66
IF UNDER 1 YEAR Months 5 Days 1
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Montemorelos N.L. Mexico
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jesus Maria Alarez BIRTHPLACE Mexico
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 450-92-0366
17. INFORMANT'S OWN SIGNATURE Alfredo Salis ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Decompensation
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* In the hospital, *19__, to* just before she died, *19__, that I last saw the deceased alive on __, 19__, and that death occurred at __ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS 222 East Elm, Caldwell
23c. DATE SIGNED 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Aug. 4, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Leonard C. Flahiff
LICENSE NO. E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3030
Local Reg. No. 8
Reg. Dist. No. 360

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 000
b. CITY OR TOWN: NAMPA
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 148
b. COUNTY: CANYON
c. CITY OR TOWN: RURAL NAMPA
d. STREET ADDRESS (If rural, give location): 205 NORTH MIDLAND BLVD.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LOUIS	A.	THOMPSON	JULY 31, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
MALE	WHITE	WIDOWED 2	DEC. 19, 1875	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
LIVESTOCK 04	RANCHING	TUSCOMBIA, MISSOURI	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
THOMAS THOMPSON	SCOTLAND	NO RECORD	MICHIGAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		519-60-1766	Mrs. Doris Johnston	NAMPA, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Thrombosis 332 X	7-22-67
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Cerebral arteriosclerosis	years
DUE TO (c)	Generalized arteriosclerosis	years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-24, 1967, *to* 7-31, 1967, *that I last saw the deceased alive on* 7-30, 1967, *and that death occurred at* 6:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marion E Blough MD 738	NAMPA, IDAHO	8-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	8-3-67	INDIAN VALLEY CEMETERY	INDIAN VALLEY, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 7 1967	Mrs. Martina Walmsley	M. B Shepherd	473

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: SHEPHERD MORTUARY

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3031
Local Reg. No. 18
Reg. Dist. No. 360

RECEIVED
AUG 14 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 140 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale
d. STREET ADDRESS (If rural, give location) Box 642

3. NAME OF DECEASED (Type or Print)
a. (First) Clarence b. (Middle) V. c. (Last) Parrill

4. DATE OF DEATH (Month) (Day) (Year) July 31, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Mar. 19, 1884
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months 4 Days 12 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Taylorville, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William H. Parrill BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Mary Angel BIRTHPLACE Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-12-634A
17. INFORMANT'S OWN SIGNATURE X Goldie A. Ward ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

157X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer pancreas — INTERVAL BETWEEN ONSET AND DEATH 3 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 7-17-67
19b. MAJOR FINDINGS OF OPERATION Cancer pancreas
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-2, 1967, *to* 7-31, 1967, *that I last saw the deceased alive on* 7-31, 1967, *and that death occurred at* 6:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 166 (Degree or title) 1
23b. ADDRESS Caldwell Ida
23c. DATE SIGNED 8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 3, 1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Gardens
24d. LOCATION (City, town, or county) Nampa, Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 11, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Leonard C. Flahiff
LICENSE NO. E-481
FIRM NAME: Homedale's Flahiff Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 29 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3032
Local Reg. No. 16
Reg. Dist. No. 360

RECEIVED
AUG 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon
b. CITY OR TOWN: Nampa
d. FULL NAME OF HOSPITAL OR INSTITUTION: Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho b. COUNTY: 142 Canyon
c. CITY OR TOWN: Nampa
d. STREET ADDRESS (If rural, give location): 219-21 Avenue South

3. NAME OF DECEASED (Type or Print): a. (First) EARL b. (Middle) W. c. (Last) RICHARDSON

4. DATE OF DEATH: (Month) July (Day) 31 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 21, 1907
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Switchman
10b. KIND OF BUSINESS OR INDUSTRY: 10 U.P. Railroad
11. BIRTHPLACE (State or foreign country): Kent, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Horace H. Richardson — BIRTHPLACE: Oregon
14. MOTHER'S MAIDEN NAME: Daisy L. McCullough — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 521 07 0059
17. INFORMANT'S OWN SIGNATURE: Mrs Viola Richardson — ADDRESS: Nampa, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 4938 Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Lung Resection 1953 (Cancer)

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 20, 19 67, *to* July 31, 19 67, *that I last saw the deceased alive on* July 31, 19 67, *and that death occurred at* 4:40A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: J.R. Mangum 322 (Degree or title)
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 8/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE REC'D BY LOCAL REG.: Aug 10, 1967
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 23 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3033
Local Reg. No. 17
Reg. Dist. No. 360

RECEIVED AUG 14 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place) 5 hrs 405
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 147
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) Box 663

3. NAME OF DECEASED (Type or Print)
a. (First) Noland
b. (Middle) Raymond 051
c. (Last) Glenn

4. DATE OF DEATH (Month) (Day) (Year) July 31, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan. 27, 1916
9. AGE (In years last birthday) 51 — IF UNDER 1 YEAR Months 6 Days 4 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY Canyon County
11. BIRTHPLACE (State or foreign country) Sedan, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Noah Glenn — BIRTHPLACE Sedan, Kansas
14. MOTHER'S MAIDEN NAME Lillie Howell — BIRTHPLACE Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 512-03-6929
17. INFORMANT'S OWN SIGNATURE x Mrs. Elsie Glenn — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic Heart Disease — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive Cardiovascular disease

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-2-67, 19__, *to* 7-31-67, 19__, *that I last saw the deceased alive on* 7-31-67, 19__, *and that death occurred at* 7:45P. *m., from the causes and on the date stated above.*

23a. SIGNATURE W. J. Huber M.D. 260 (Degree or title)
23b. ADDRESS 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED 8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 3, 1967
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 11, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Leonard C. Flahiff
LICENSE NO. E-481

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3034
Local Reg. No. 1722
Reg. Dist. No. 470

BIRTH NO.

JUL 14 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 161 Cassia 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (If in hospital): None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 480 E. 200 S. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 32 New Mexico
b. COUNTY: 555 McKinley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gallup
d. STREET ADDRESS (If rural, give location): *******

3. NAME OF DECEASED (Type or Print)
a. (First): Bennie
b. (Middle):
c. (Last): Cadman

4. DATE OF DEATH (Month) (Day) (Year): July 2, 1967

5. SEX: male
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: July 20, 1938
9. AGE (In years last birthday): 28 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: *****
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Sam Cadman - Ft. Defiance, Arizona
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Mary Watson - Ft. Defiance, Ariz.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): ?
16. SOCIAL SECURITY NO.: 529-42-6578
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Info taken from personal effects & telephone call to Reservation

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Massive head injury — INTERVAL BETWEEN ONSET AND DEATH: 28 minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 160 (STATE): Rural Cassia County Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 2, 1967 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: auto accident

22. *I hereby certify that I attended the deceased from* Investigated the death *, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 10:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Leslie L Fillmore MD Coroner
583 (Degree or title)
23b. ADDRESS: Box 657 Burley Idaho
23c. DATE SIGNED: 7-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 7/6/67
24c. NAME OF CEMETERY OR CREMATORY: ***
24d. LOCATION (City, town, or county) (State): Gallup, New Mexico

DATE REC'D BY LOCAL REG.: July 13, 1967
REGISTRAR'S SIGNATURE: Bill H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Payne Mortuary

JUN 16 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 2 1992

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3035
Local Reg. No. 1721
Reg. Dist. No. 479

RECEIVED
JUL 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 160 Cassia 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley -rural
STAY (in this place) I Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) rural road-Springdale area

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 02 Arizona
b. COUNTY 555 Apache
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lupton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Michael
b. (Middle) 000
c. (Last) Navaho

4. DATE OF DEATH (Month) July (Day) 2, (Year) 1967

5. SEX Male
6. COLOR OR RACE Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH March 5, 1951
9. AGE (In years last birthday) 16 | IF UNDER 1 YEAR Months 3 Days 29 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labprer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lupton, Arizona
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Isaac Navaho, BIRTHPLACE Lupton, Arizona
14. MOTHER'S MAIDEN NAME Lena Chatto BIRTHPLACE Lupton, Arizona

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - -
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Jimmy Navaho ADDRESS Lupton Arizona

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Chest injury with vomiting & aspiration — INTERVAL BETWEEN ONSET AND DEATH 20 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 06
21c. (CITY, TOWN, OR TOWNSHIP) Rural 13 (COUNTY) 160 Cassia (STATE) Idaho
21d. TIME OF INJURY (Month) July (Day) 2, (Year) 1967 (Hour) 2 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? auto accident

22. I hereby certify that I attended the deceased from July 2, 1967 to July 2, 1967, that I last saw the deceased alive on July 2, 1967, and that death occurred at 10:05 P m., from the causes and on the date stated above.

23a. SIGNATURE Leslie E. Ellmaker M.D. (Degree or title) Coroner
23b. ADDRESS Box 957 Burley Ida
23c. DATE SIGNED 7-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE July 11, 1967
24c. NAME OF CEMETERY OR CREMATORY Gallup Cemetery
24d. LOCATION (City, town, or county) Gallup, McKinley Co. (State) New Mex.

DATE REC'D BY LOCAL REG. July 13 1967
REGISTRAR'S SIGNATURE Beth N Pearson
25. EMBALMER Ormand J Burch
LICENSE NO. E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3036
Local Reg. No. 1719
Reg. Dist. No. 470

RECEIVED JUL 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia 308
b. CITY OR TOWN Burley
LENGTH OF STAY (in this place) 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 38 Oregon
b. COUNTY 555 Multnomah
c. CITY OR TOWN Portland - Rural
d. STREET ADDRESS (If rural, give location) Rt. # 2 Box 404 Zip 97231

3. NAME OF DECEASED (Type or Print)
a. (First) Jesse
b. (Middle) E
c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) July 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Dec. 9, 1897	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver 27	various	near Franklin, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Francis Smith - Unknown		Ellen Chism - Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unknown	**	Mae O. Smith	Portland, Or

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 7 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — 3 Yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 25 June, 1967 *to* 2 July, 1967, *that I last saw the deceased alive on* 1 July, 1967, *and that death occurred at* 4:02 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Chas M. Blume 526	MD	Burley Idaho	7 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7/3/67	Skyline Mem. Gardens	Portland, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 12 1967	Ruth A. Pearson		E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3037
Local Reg. No. 1724
Reg. Dist. No. 470

BIRTH NO.

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 16 / Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 160
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
d. STREET ADDRESS (If rural, give location): 501 N. Center

3. NAME OF DECEASED (Type or Print)
a. (First): Dazel
b. (Middle): Dell
c. (Last): Howells

4. DATE OF DEATH (Month) (Day) (Year): July 6, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 12, 1894

9. AGE (In years last birthday): 72
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Oakley, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Carl Bedke
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Polly Ann McIntosh
BIRTHPLACE: Grantsville, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-52-1568

17. INFORMANT'S OWN SIGNATURE: X Bernice Howells
ADDRESS: Oakley, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial eschemia — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Aortic stenosis with pulmonary hypertension — 5 - 7 yr

DUE TO (c): Cor pulmonale

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Generalized arteriosclerosis — 7 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-20-58, 19___, *to* 7-6-67, 19___, *that I last saw the deceased alive on* 7-5-67 19___, *and that death occurred at* 4:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE: 526 (Degree or title): MD

23b. ADDRESS: 1341 Overland Ave. Burley, Idaho

23c. DATE SIGNED: 7-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: 7/6/67

24c. NAME OF CEMETERY OR CREMATORY: Mt. View Memorial

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: July 20 1967

REGISTRAR'S SIGNATURE: Beth H. Pearson

25. EMBALMER:

LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 1 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3038
Local Reg. No. 1723
Reg. Dist. No. 470

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia 136
b. CITY OR TOWN Burley
c. LENGTH OF STAY (in this place) 30 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 870

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 167 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 818 Elba Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Dent	Jefferson	Faught	July	8,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	August 13, 1886	80	10	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06		Harrison, Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jefferson Faught	Unknown	Lucy (Unknown)	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	— — — —	518-22-8720	Anna Faught	Burley-Idaho, 818 Elba Ave

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 3-4 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) With rectal invasion — 2-3 mo
DUE TO (c) resulting in Hemorrhage & Diarrhea Severe — 1 mo

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/9/67	Biopsy rectal Tumor	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
None				

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
None m.		

22. *I hereby certify that I attended the deceased from* 12-31-, 1962, *to* 7-8-, 1967, *that I last saw the deceased alive on* 7-7-1967, *and that death occurred at* ____ A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R Sutton	514 MD	Burley Idaho	7/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 12, 1967	Gem Memorial Gardens	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 18 1967	Beth A Pearson	Ormand Burch	E-471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 - inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 5 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3039
Local Reg. No. 1720
Reg. Dist. No. 470

BIRTH NO.

RECEIVED
JUL 14 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 161 Cassia
b. CITY OR TOWN Burley
c. LENGTH OF STAY (If hospital or institution) hours
d. FULL NAME OF HOSPITAL OR INSTITUTION Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 168 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malta - rural
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Herbert b. (Middle) Raymond c. (Last) Stephens

4. DATE OF DEATH (Month) July (Day) 8, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 31, 1905
9. AGE (In years last birthday) 61 — IF UNDER 1 YEAR Months 6 Days 7 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Osmond, Wyoming
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Edmond Alexander Stephens — BIRTHPLACE No. Ogden Utah
14. MOTHER'S MAIDEN NAME Mary Stones, Wilson Lane, Weber Co. BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-38-9960
17. INFORMANT'S OWN SIGNATURE Box 81 Rhoda Stephens Malta Idaho ADDRESS 83324

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5920

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 8-10 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ch. Bronchitis + Emphysema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Suspect myocardial infarct

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-19, 1966 to 7-8, 1967, that I last saw the deceased alive on 7-8, 1967, and that death occurred at 8:00 Am., from the causes and on the date stated above.

23a. SIGNATURE Walter R. Arm MD (Degree or title)
23b. ADDRESS 1335 Albion Burley, Ida
23c. DATE SIGNED 7-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 12, 1967
24c. NAME OF CEMETERY OR CREMATORY Malta Cemetery
24d. LOCATION (City, town, or county) Malta, (State) Idaho

DATE REC'D BY LOCAL REG. July 13 1967
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER Ormand Burch
LICENSE NO. E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17, to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS By Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 21 1967 BUREAU OF VITAL STATISTICS

State File No. 3040
Local Reg. No. 1725
Reg. Dist. No. 470

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 16 Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
LENGTH OF STAY (in this place) months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 627 Malta Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16
b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 627 Malta Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Cheryl	Elaine	Wilkinson	July 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	white	married 3	Dec. 21, 1945	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 21	Home	American Falls, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Earl Orlando Savage-[illegible]	[illegible], Idaho	Valeria Dyer - Oakley, Idaho	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-52-0925	Helena Wilkinson	Burley

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Glioblastoma Multiformis of Brain. — INTERVAL BETWEEN ONSET AND DEATH: 10 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 1938
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov 66	Brain Tumor.	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March 7, 1966, *to* July 14, 1967, *that I last saw the deceased alive on* July 14, 1967, *and that death occurred at* 7:45 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] Rucker 283	MD	Burley Idaho	7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/18/67	Pleasant View Cemetery	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 20, 1967	Rick A. Pearson	[illegible]	E 989

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3041
Local Reg. No. 1728
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 161 Cassia 154
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 54 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1300 Burton Avenue 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 161 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1300 Burton Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Elizabeth
b. (Middle):
c. (Last): Burton

4. DATE OF DEATH (Month) (Day) (Year): July 14, 1967

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct. 27, 1883
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months 8, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Barton, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Forman — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Sarah Webster — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: 518-48-4406 / 519-44-8806
17. INFORMANT'S OWN SIGNATURE: Roy J. Forman Antelope, Ore. — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 331X Probable Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): none
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Investigated, *to* the death of, *19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 9 P*m., from the causes and on the date stated above.*

23a. SIGNATURE: Leslie S Fillmore MD 583 (Degree or title) Carmer 4
23b. ADDRESS: Box 651 Burley Idaho
23c. DATE SIGNED: 7-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sandy Ridge Cemetery
24d. LOCATION (City, town, or county) (State): Sandy, Oregon

DATE REC'D BY LOCAL REG.: July 26, 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Very B. McCulloch
LICENSE NO.: E-260

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 12 1967

NOV 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3042
Local Reg. No. 1729
Reg. Dist. No. 470

BIRTH NO.

AUG - 1 1967

1. PLACE OF DEATH
a. COUNTY 161 Cassia 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place) a few Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho Hotel-Overland Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 300
b. COUNTY Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Leadore
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) 000
c. (Last) Davis

4. DATE OF DEATH (Month) July (Day) 15, (Year) 1967

5. SEX male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown 0

8. DATE OF BIRTH Nov. 14, 1899

9. AGE (In years last birthday) 67 — If under 1 year: Months 8, Days 1 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Tonopah, Nevada ?

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) - - - - -

16. SOCIAL SECURITY NO. 516-42-2551

17. INFORMANT'S OWN SIGNATURE From Dr. records — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchogenic Carcinoma — mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-24, 19 62, *to* 7-15, 19 67, *that I last saw the deceased alive on* 7-10, 19 67, *and that death occurred at* 7 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE W R Arno 709 (Degree or title)

23b. ADDRESS Burley, Idaho

23c. DATE SIGNED 7-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE July 20, 1967

24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery

24d. LOCATION (City, town, or county) Burley (State) Idaho

DATE REC'D BY LOCAL REG. July 26 1967

REGISTRAR'S SIGNATURE Bert A. Pearson

25. EMBALMER Ormand Burch

LICENSE NO. E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3043
Local Reg. No. 1726
Reg. Dist. No. 470

Certificate of Death

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place) 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 340 Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
d. STREET ADDRESS (If rural, give location) Box #12

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) 070
c. (Last) Oliver

4. DATE OF DEATH (Month) (Day) (Year) July 15, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Feb 11, 1911
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Driver 27
10b. KIND OF BUSINESS OR INDUSTRY Trucking
11. BIRTHPLACE (State or foreign country) Return, So. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lonnie L. Oliver — BIRTHPLACE Habersham, Geo.
14. MOTHER'S MAIDEN NAME Rosa Reynolds — BIRTHPLACE So. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) * * *
16. SOCIAL SECURITY NO. 573-58-9862
17. INFORMANT'S OWN SIGNATURE Roger K. Oliver — ADDRESS Heyburn, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1578

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF PANCREAS — INTERVAL BETWEEN ONSET AND DEATH 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-5-67, 19__, *to* 7-15-67, 19__, *that I last saw the deceased alive on* 7-14-67 19__, *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Eugene L. Schwiger 239 (Degree or title) M.D. 1
23b. ADDRESS Burley, Idaho
23c. DATE SIGNED 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/17/67
24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State) Burley, Idaho

DATE REC'D BY LOCAL REG. July 20, 1967
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER [signature]
LICENSE NO. E 389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3044
Local Reg. No. 1727
Reg. Dist. No. 470

RECEIVED AUG - 1 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley 000
c. LENGTH OF STAY (in this place) ---
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 078

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 43 Utah
b. COUNTY 533 Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salt Lake City
d. STREET ADDRESS (If rural, give location) 1349 Brian

3. NAME OF DECEASED (Type or Print)
a. (First) KURT
b. (Middle) TODD
c. (Last) BRANDL

4. DATE OF DEATH (Month) July (Day) 16, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH June 8, 1967

9. AGE (In years last birthday) ---
IF UNDER 1 YEAR Months 1 Days 8
IF UNDER 24 HRS. Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----- 02

10b. KIND OF BUSINESS OR INDUSTRY -----

11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Peter Brandl
BIRTHPLACE West Germany

14. MOTHER'S MAIDEN NAME Shirley Louise Allen
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. ---

17. INFORMANT'S OWN SIGNATURE X Peter Brandl
ADDRESS Salt Lake City, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intracranial Bleeding + Trauma — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Skull fracture + Trauma — 2 hrs
DUE TO (c) Auto accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hiway 06

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 340 **(STATE)** Minidoka, Idaho

21d. TIME OF INJURY (Month) 7 (Day) 16 (Year) 67 (Hour) 6 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? auto accident

22. *I hereby certify that I attended the deceased from* 7-16-67 *to* 7-16-67, *that I last saw the deceased alive on* 7-16-67, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 709 1

23b. ADDRESS Burley, Idaho

23c. DATE SIGNED 7.19.67

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 3

24b. DATE 7.19.67

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. July 26-67

REGISTRAR'S SIGNATURE Ruth H. Pearson

25. EMBALMER [signature]

LICENSE NO. E-343

FIRM NAME: WHITE MORTUARY 733-6600 Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 28 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3045
Local Reg. No. 1733
Reg. Dist. No. 470

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 161
b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 2043 Oakley Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) ALBERT
b. (Middle) J.
c. (Last) ANDERSON

4. DATE OF DEATH (Month) (Day) (Year) July 17, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH June 23, 1908
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Store Manager 26
10b. KIND OF BUSINESS OR INDUSTRY Auto-parts
11. BIRTHPLACE (State or foreign country) Albia, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME A.R. Anderson — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Annie Burt — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-05-8648
17. INFORMANT'S OWN SIGNATURE x Marvin L. Anderson — ADDRESS College Place, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Toxic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 17da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hepatic Cirrhosis 6mo.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Toxic Psychosis 10da.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-30, 1967 *to* 7/17/, 1967, *that I last saw the deceased alive on* 7-17, 1967, *and that death occurred at* 2:15a. *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 276 (Degree or title) M.D. 1
23b. ADDRESS Burley, Idaho
23c. DATE SIGNED 7-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 17
24b. DATE 7/20/67
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Aug 2 1967
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER Paul D. Reynolds [signature]
LICENSE NO. E-495

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3046
Local Reg. No. 1731
Reg. Dist. No. 470

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia AUG - 1 1967 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 348 Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
d. STREET ADDRESS (If rural, give location) R.F.D.

3. NAME OF DECEASED (Type or Print)
a. (First) Leslie
b. (Middle) Edmond
c. (Last) Bowman

4. DATE OF DEATH (Month) (Day) (Year) July 17, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Oct. 8, 1889
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Ogden, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Archie Bowman-West Weber, Utah — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Eunice Wattis - Uinta, Utah — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-42-1370
17. INFORMANT'S OWN SIGNATURE Mabel C. Bowman — ADDRESS Heyburn, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

154X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Toxemia of Edna Carcinoma of Rectum
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 3 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-20-67, 19__, *to* 7-17-67, 19__, *that I last saw the deceased alive on* 7-17-67, *and that death occurred at* 8:50 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 526 (Degree or title) MD
23b. ADDRESS Burley, Idaho
23c. DATE SIGNED 7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 7/20/67
24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery
24d. LOCATION (City, town, or county) (State) Heyburn, Idaho

DATE REC'D BY LOCAL REG. July 26 1967
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER [signature]
LICENSE NO. E-389

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3047
Local Reg. No. 1730
Reg. Dist. No. 470

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG - 1 1967

Bureau of V

1. PLACE OF DEATH
a. COUNTY 161 Cassia 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
d. STREET ADDRESS (If rural, give location) S- 18th

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle)
c. (Last) Alanis

4. DATE OF DEATH (Month) (Day) (Year) July 18, 1967

5. SEX Male
6. COLOR OR RACE Spanish
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 6, 1900
9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR Months 11 Days 12 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pueblo, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Faustino Alanis — BIRTHPLACE Mexico
14. MOTHER'S MAIDEN NAME Unknown (Lopez) — BIRTHPLACE Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. 518-24-5508
17. INFORMANT'S OWN SIGNATURE Jean Alanis — ADDRESS S-18th Heyburn Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH 1 wk

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Generalized Arteriosclerosis — 3-4 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Thyrotoxicosis Mod. — 2-3 yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-23-65, 19__, *to* 7-18-67, 19__, *that I last saw the deceased alive on* 7-18-67, 19__, *and that death occurred at* 3:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 526 (Degree or title) MD 1
23b. ADDRESS Burley, Idaho
23c. DATE SIGNED 7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 24, 1967
24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery,
24d. LOCATION (City, town, or county) Burley, (State) Idaho

DATE REC'D BY LOCAL REG. July 26, 1967
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER Ormand F. Bunch
LICENSE NO. E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signature of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 3 1967
AUG 8 1967
OCT 17 1969
NOV 28 1969
JUL 23 1986

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3048
Local Reg. No. 1732
Reg. Dist. No. 470

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 470

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 161 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 1800 Miller Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Josephine
b. (Middle) Robb
c. (Last) Lynch

4. DATE OF DEATH (Month) (Day) (Year) July 23, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Nov. 29, 1883
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Scottsville, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-05-5529
17. INFORMANT'S OWN SIGNATURE C. L. Lynch — ADDRESS Burley, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 14 da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Gastroenteritis — 10 da.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-11, 1967, *to* 7-23, 1967, *that I last saw the deceased alive on* 7-23, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 276 (Degree or title) Lyn Kelly
23b. ADDRESS Burley
23c. DATE SIGNED 7-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 7/26/67
24c. NAME OF CEMETERY OR CREMATORY Pleasant View
24d. LOCATION (City, town, or county) (State) Burley, Idaho

DATE REC'D BY LOCAL REG. Aug. 2 1967
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER [signature]
LICENSE NO. E-389

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3049
Local Reg. No. 1734
Reg. Dist. No. 470

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place) 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 160 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Oakley
d. STREET ADDRESS (If rural, give location) **********

3. NAME OF DECEASED (Type or Print)
a. (First) Francis
b. (Middle) Lewis
c. (Last) Elison

4. DATE OF DEATH (Month) (Day) (Year) July 26, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH Feb. 24, 1887

9. AGE (In years last birthday) 80
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Oakley, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew Elison — BIRTHPLACE Sweden

14. MOTHER'S MAIDEN NAME Johanna Swenson — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-42-5485

17. INFORMANT'S OWN SIGNATURE Willard Elison — ADDRESS Burley, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5-7 Dy

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — 3-5 yr

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12-53, 19___, *to* 7-26-67, 19___, *that I last saw the deceased alive on* 7-26-67, 19___, *and that death occurred at* 7:25 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 526 (Degree or title)

23b. ADDRESS Burley, Idaho

23c. DATE SIGNED 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/29/67

24c. NAME OF CEMETERY OR CREMATORY Oakley Cemetery

24d. LOCATION (City, town, or county) (State) Oakley, Idaho

DATE REC'D BY LOCAL REG. Aug 2 1967

REGISTRAR'S SIGNATURE Buck B. Pearson

25. EMBALMER [signature]

LICENSE NO. E-384

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3050
Local Reg. No. 1735
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 16 Cassia AUG 8 - 1967 202
b. CITY OR TOWN Burley
c. LENGTH OF STAY IN (this place) months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Burley Nursing Home 290

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 260
b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rigby
d. STREET ADDRESS (If rural, give location) **********

3. NAME OF DECEASED (Type or Print)
a. (First) Elizabeth
b. (Middle)
c. (Last) Nalder

4. DATE OF DEATH (Month) (Day) (Year) July 31, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH July 27, 1885

9. AGE (In years last birthday) 82
If under 1 year: Months | Days
If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 81

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Kaysville, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph Henry Morgan-Kaysville, Ut.
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Sushannah Harvey - Kaysville, Ut.
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 519-05-0810

17. INFORMANT'S OWN SIGNATURE Lloyd M Nalder
ADDRESS Shelley

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4918

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 0
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 25, 1964, *to* Aug 31, 1967, *that I last saw the deceased alive on* May 3, 1967, *and that death occurred at* 7:32 A m., *from the causes and on the date stated above.*

23a. SIGNATURE A R Bircher (Degree or title) M.D.
23b. ADDRESS Burley Idaho
23c. DATE SIGNED 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 7/31/67
24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery
24d. LOCATION (City, town, or county) (State) Rigby, Idaho

DATE REC'D BY LOCAL REG. Aug. 4 1967
REGISTRAR'S SIGNATURE Ruth H. Pearson
25. EMBALMER
LICENSE NO. E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 24 2000

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3051
Local Reg. No. 660
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JUL 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 176 Clark 123
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dubois
c. LENGTH OF STAY (in this place) 23 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 170
b. COUNTY Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dubois
d. STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print)
a. (First) OSCAR
b. (Middle) LAVERNE
c. (Last) COOK

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 19, 1904
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assessor 08
10b. KIND OF BUSINESS OR INDUSTRY: County Govt.
11. BIRTHPLACE (State or foreign country): Albion, Idaho.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Cook Jr. — BIRTHPLACE: Garfield, Ut.
14. MOTHER'S MAIDEN NAME: Lulu Fuller — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-07-4986
17. INFORMANT'S OWN SIGNATURE: Ida May Cook — ADDRESS: Dubois, Ida.

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — 1 month

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1950, *to* July 3, 1967, *that I last saw the deceased alive on* June 29, 1967, *and that death occurred at* 11:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE: A. Lowell 5371 (Degree or title) M.D. 1
23b. ADDRESS: Rexburg, Idaho.
23c. DATE SIGNED: 7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 7
24b. DATE: July 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Groveland
24d. LOCATION (City, town, or county) (State): Groveland Bingham Ida.

DATE REC'D BY LOCAL REG.: 7/10/67
REGISTRAR'S SIGNATURE: Jo Ann S. Lavenner
25. FUNERAL DIRECTOR: Bruce A. Eckersell — ADDRESS: Rigby, Idaho.
Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of Bruce A. Eckersell Lic. No. E-404 at Rigby, Idaho. July 3, 1967

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3052
Local Reg. No. 60
Reg. Dist. No. 210

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO. 101

1. PLACE OF DEATH
a. COUNTY Clearwater 18
b. CITY OR TOWN Orofino
c. LENGTH OF STAY (In this place) 1 yr. 3 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28
b. COUNTY Kootenai 1
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 818 East Garden Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	IDA	B.	STEVENS	July	2	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	March 30, 1890	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Oregon	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Bales	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		unknown	Christine Plourde	Records Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia, bilateral — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — Several years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary tuberculosis (arrested) — Many years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February 10, 1967 *to* July 2, 1967, *that I last saw the deceased alive on* July 2, 1967, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
595 William M. Russell	M.D.	Box 672, Orofino, Idaho	July 5, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	July 3, 1967	Yates Funeral Home	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 6, 1967	Josephine K Gilbert	Lyle A. Stutzman	476

FIRM NAME GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3053
Local Reg. No. 61
Reg. Dist. No. 210

BIRTH NO.

RECEIVED JUL 21 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 2 yrs 2 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 280
b. COUNTY: Kootenai 102
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print): a. (First) DENNIS; b. (Middle); c. (Last) BURGE

4. DATE OF DEATH: (Month) July (Day) 4 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 1891

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours. / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sawmill worker (retired) 17

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Washington

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME (maiden name unknown): Barbara Burge — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-01-8599

17. INFORMANT'S OWN SIGNATURE: Christine Plounde — Records — ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: about 12 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death*: Chronic brain syndrome, arterio-sclerosis with psychosis — Many years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April 11, 1967, *to* July 4, 1967, *that I last saw the deceased alive on* July 4, 1967, *and that death occurred at* 8:35 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 695 (Degree or title) M.D. 1

23b. ADDRESS: Box 672, Orofino, Idaho

23c. DATE SIGNED: July 5, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: July 5, 1967

24c. NAME OF CEMETERY OR CREMATORY: Yates Funeral Home

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: July 6, 1967

REGISTRAR'S SIGNATURE: Josephine B. Gilbert

25. EMBALMER: [signature]

LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 1 7 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3054
Local Reg. No. 62
Reg. Dist. No. 210

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 10 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orofino--rural farm 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 180
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): GUY
c. (Last): DINNISON

4. DATE OF DEATH (Month) (Day) (Year): July 5 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: July 3, 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Liberty, Penn.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Dinnison — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Anna Guy — BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-14-5489
17. INFORMANT'S OWN SIGNATURE: x Mrs. R. G. Dinnison — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9121

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushed chest — INTERVAL BETWEEN ONSET AND DEATH: inst.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Tractor accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): farm 02
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Orofino 13 Clearwater 180 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 5 1967 7:00 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Tractor over turned

22. *I hereby certify that I attended the deceased from* never, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 7:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Larry D. Wunderlich — 583 (Degree or title): Coroner 4
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: July 6, '67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial 1
24b. DATE: July 8 1967
24c. NAME OF CEMETERY OR CREMATORY: Weippe
24d. LOCATION (City, town, or county) (State): Weippe Idaho

DATE REC'D BY LOCAL REG.: July 7 '67
REGISTRAR'S SIGNATURE: Josephine K. Gilbert
25. EMBALMER: Ty C. A. Strottmann — LICENSE NO. 476

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3055
Local Reg. No. 63
Reg. Dist. No. 210

BIRTH NO.

RECEIVED JUL 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe
c. LENGTH OF STAY (in this place): 11 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Own Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RUBY	DELL	CHENETTE	July 5 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 3	Sept. 28, 1898	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Townsend, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oscar Hesse	Germany	Maria Holmes	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		542-12-5751A	X Leslie Chenette	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: min.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* never, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 2:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Larry D. Wunderlich	563 Coroner 24	Orofino, Idaho	July 7 '67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 7, 1967	Riverside	Orofino Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 7 '67	Josephine K. Gilbert	Lyle A. Stratman	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3056
Local Reg. No. 64
Reg. Dist. No. 210

Certificate of Death

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CV Hospital 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 180
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ahsahka
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): THOMAS
b. (Middle): B.
c. (Last): DOUGLASS

4. DATE OF DEATH (Month) (Day) (Year): July 7, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: May 9, 1906
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill worker 17
10b. KIND OF BUSINESS OR INDUSTRY: Timber
11. BIRTHPLACE (State or foreign country): Conshohocken, Penna.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Douglass — BIRTHPLACE: Conshohocken Pa.
14. MOTHER'S MAIDEN NAME: Abie Warburton — BIRTHPLACE: Conshohocken, Pa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 187-10-1226
17. INFORMANT'S OWN SIGNATURE: x Margaret Bailey — ADDRESS: Penna.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-3, 1967, *to* 7-7, 1967, *that I last saw the deceased alive on* 7-7, 1967 *and that death occurred at* 10 59 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 038
23b. ADDRESS: Orofino Idaho
23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: July 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county): Orofino (State): Idaho

DATE REC'D BY LOCAL REG.: July 15, 1967
REGISTRAR'S SIGNATURE: Josephine K. Gilbert
25. EMBALMER: Fyl A. Strottmann
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 7 1993

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3057
Local Reg. No. 65
Reg. Dist. No. 210

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater 180 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CV Hospital 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 180 b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location) Route # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MATILDA	A.	BLOOM	July	8	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 3	Oct. 2, 1918	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Spokane, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Groh — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Elvina Myers — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-01-4233
17. INFORMANT'S OWN SIGNATURE x Hazel B Loomis ADDRESS Orofino, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4438

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardial vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Essential hypertension — 20 years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 1967 *to* July, 1967, *that I last saw the deceased alive on* July 8, 1967 *and that death occurred at* 6:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Northside Medical Route 3, Orofino, Idaho	July 10, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 11, 1967	Riverside	Orofino Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 13, 1967	Josephine K. Gilbert	Lyle A. Stutzmann	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3058
Local Reg. No. 66
Reg. Dist. No. 210

BIRTH NO.

AUG - 1 1967
Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Clearwater 180 381

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino

c. LENGTH OF STAY (In this place): 1 day

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CV Hospital 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 258

b. COUNTY: Idaho

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAMES	HARRY	SAID	July 20 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	divorced 4	April 16, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cedar Maker 17	Wood products	Burlington, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Henry Said	Iowa	Mahalia ?	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
unknown WW I 3	518-05-3040	M. L. Burgs. (by J.D.)	Kooskia, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Pyelonephritis — 3-4 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1967, *to* July, 1967, *that I last saw the deceased alive on* 7-20, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
038		7-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 24, 1967	Pine Grove	Kooskia Idaho Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 24, 1967	June M. Powell	by A. Strattman	476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: TRENARY FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3059
Local Reg. No. 68
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG - 1 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 180 Clearwater 101 20
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (in this place) 7 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 281
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 908 9th Street North

3. NAME OF DECEASED (Type or Print)
a. (First) DEE
b. (Middle)
c. (Last) WAKEFIELD

4. DATE OF DEATH (Month) 7 (Day) 22 (Year) 67

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 4-20-90
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gun Smith 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Paris Wakefield — BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Barbara DeVoie — BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) unknown
16. SOCIAL SECURITY NO. unknown
17. INFORMANT'S OWN SIGNATURE Kaye Wilson — ADDRESS Records, Orofino, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular occlusion, right side (Thrombosis) — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Generalized arteriosclerosis — Many years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic brain syndrome due to arteriosclerosis — Unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 26, 1967, *to* July 22, 1967, *that I last saw the deceased alive on* July 22, 1967, *and that death occurred at* 5:25 a *m., from the causes and on the date stated above.*

23a. SIGNATURE William M. Russell 595 (Degree or title) MD
23b. ADDRESS Box 672 Orofino, Idaho
23c. DATE SIGNED July 24, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE July 22, 1967
24c. NAME OF CEMETERY OR CREMATORY Yates Funeral Home
24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho

DATE REC'D BY LOCAL REG. July 28, 1967
REGISTRAR'S SIGNATURE June M. Russell
25. EMBALMER Lyle A. Strottmann
LICENSE NO. 476

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3060
Local Reg. No. 69
Reg. Dist. No. 210

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 10 Clearwater 131
b. CITY OR TOWN Orofino
c. LENGTH OF STAY IN THIS PLACE 31 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION Own Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 180 b. COUNTY Clearwater
c. CITY OR TOWN Orofino
d. STREET ADDRESS Route # 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CECIL	GLEN	ERICKSON	July 22 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	July 17, 1907	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Millworker-Farmer	Timber	Newman Grove, Nebr.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur Erickson	unknown	Lavina Johnson	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-01-6253	x Theresa Erickson	Orofino, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Probably Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-12-67	Chronic duodenal ulcer with pyloric obstruction	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-11 *, 1967, to* 7-21 *, 19 67, that I last saw the deceased alive on* 7-21 *, 19 67, and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John F. Bamy. MD 028	347 St. Johns Way Lewiston, Idaho	7/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 25, 1967	L-C Memorial Gardens	Lewiston Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 28, 1967	June M. Powell	Lyle A. Stottmann	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 15 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

AUG - 1 1967

Bureau of Vital Statistics

State File No. 3061
Local Reg. No. 67
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater 180 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (in this place) 10 Hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CV Hospital 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 180 b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location) Johnson Avenue

3. NAME OF DECEASED (Type or Print) a. (First) LEO b. (Middle) W. c. (Last) MOORE

4. DATE OF DEATH (Month) July (Day) 23 (Year) 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH Jan. 15, 1918

9. AGE (In years last birthday) 49 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill worker

10b. KIND OF BUSINESS OR INDUSTRY Timber

11. BIRTHPLACE (State or foreign country) Branson, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Martin C. Moore BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Susie Hodge BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO. 721-07-7175

17. INFORMANT'S OWN SIGNATURE Lloyd L Moore (by J.O.) ADDRESS Orofino, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

42 81

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 15 hrs.

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD — 5-8 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23, 1967, *to* 7-23, 1967, *that I last saw the deceased alive on* 7-23, 1967, *and that death occurred at* 4:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 430 — 23b. ADDRESS Orofino, Idaho — 23c. DATE SIGNED July 25 '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE July 26, 1967 — 24c. NAME OF CEMETERY OR CREMATORY Wells Bench — 24d. LOCATION (City, town, or county) Orofino (State) Idaho

DATE REC'D BY LOCAL REG. June 26, 1967 — REGISTRAR'S SIGNATURE June M. Powell — 25. EMBALMER — LICENSE NO. 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 1 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3062
Local Reg. No. 70
Reg. Dist. No. 210

BIRTH NO.

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 180 Clearwater — AUG 14 1967 — 384
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY in this place: 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 310
b. COUNTY: Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
d. STREET ADDRESS (If rural, give location): Kamiah, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) ELSIE b. (Middle) MAE 073 c. (Last) SPIVY

4. DATE OF DEATH (Month) (Day) (Year): July 30, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Nov 6, 1879

9. AGE (In years last birthday): 87 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 07

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Dayton, Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Marlett — BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Mary Kenoyer — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Lawana Spivey — ADDRESS: Kamiah, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 4918 Double pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3d

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Hydrone pleritis — 6 wks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 19 67 *to* July, 19 67, *that I last saw the deceased alive on* 7-30-, 1967, *and that death occurred at* 2:45 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] — **23b. ADDRESS**: Lewiston Idaho — **23c. DATE SIGNED**: 8-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Aug 1, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Normal Hill — **24d. LOCATION** (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: August 4, 1967 — **REGISTRAR'S SIGNATURE**: June M. Burell — **25. EMBALMER**: Lyle A. Robertson — **LICENSE NO.**: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: ROBERTSON-HANSEN FH

FEB 5 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3063
Local Reg. No. 5
Reg. Dist. No. 680

BIRTH NO.

RECEIVED
AUG 11 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Custer 190 — 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural Stanley
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 mi. West — 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 430
b. COUNTY: Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WILLIAM	R.	BARKELL	July 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Sept. 9 1928	38		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Logger, J. I. Morgan Co. 17		Torrington, Wyoming	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John R. Barkell	Nebraska	Sylvia Putnam	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Korean War 7	548-34-2191	Leta L. Barkell	McCall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Multiple accident injuries — INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Collision

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: D.O.A.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Highway 1	West of Stanley 6	13 190	Custer	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
approx. midnite m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Head on collision

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 7 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. W. Huber, M.D. 385	1	Jerome	5 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 2, 1967	McCall Cemetery	McCall Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-8-67	Mrs Laurence J. Mulder	Burt Bird	E 373

FIRM NAME: BIRD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3064
Local Reg. No. 4
Reg. Dist. No. 680

Certificate of Death

RECEIVED AUG 1 1 1967

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 190 Custer 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) West of Stanley
c. LENGTH OF STAY (in this place) none
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) In route to Sun ValleyHosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 430
b. COUNTY Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
d. STREET ADDRESS (If rural, give location) **********

3. NAME OF DECEASED (Type or Print)
a. (First) Loreine
b. (Middle) B. 000
c. (Last) Thurston

4. DATE OF DEATH (Month) (Day) (Year) July 30, 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH July 6, 1930
9. AGE (In years last birthday) 37 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Burley, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME R. Dean Hartwell — BIRTHPLACE Salt Lake City, Ut.
14. MOTHER'S MAIDEN NAME Nina E. Sanders — BIRTHPLACE Diaz, Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-30-3686
17. INFORMANT'S OWN SIGNATURE Glen E. Thurston — ADDRESS Cascade, Idaho

8164

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple accident injuries — INTERVAL BETWEEN ONSET AND DEATH 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Collision
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Hiway 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) West of Stanley 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 190 (COUNTY) Custer (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Head on collision

22. *I hereby certify that I attended the deceased from ——, 19__, to ——, 19__, that I last saw the deceased alive on 30 Jul, 1967, and that death occurred at 1:30 A.m., from the causes and on the date stated above.*

23a. SIGNATURE R. M. Leber, M.D. 385 (Degree or title) 1
23b. ADDRESS Jerome
23c. DATE SIGNED 5 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7/30/67
24c. NAME OF CEMETERY OR CREMATORY Gem Memorial Gardens
24d. LOCATION (City, town, or county) (State) Burley, Idaho

DATE REC'D BY LOCAL REG. 8-8-67
REGISTRAR'S SIGNATURE Mrs. Pauline J. Mulder
25. EMBALMER Keith Bird Keith Bird
LICENSE NO. E 373

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bird Funeral Home, Hailey, Ida

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3065
Local Reg. No. 49
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 200 Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 8 days 308
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 088

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 200
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
d. STREET ADDRESS (If rural, give location) 445 South 2nd East

3. NAME OF DECEASED (Type or Print)
a. (First) MRS. b. (Middle) LOVANTIA c. (Last) WEAVER

4. DATE OF DEATH (Month) (Day) (Year) July 5, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 28, 1876
9. AGE (In years last birthday) 90 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Centerville, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Steuben Rollins — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Card — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* July 5, 1967, *that I last saw the deceased alive on* July 5, 1967, *and that death occurred at* 7:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Malone W. Koelsch 289 (Degree or title) MLO
23b. ADDRESS Mountain Home Idaho
23c. DATE SIGNED July 26 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7/6/67
24c. NAME OF CEMETERY OR CREMATORY Bountiful, Utah
24d. LOCATION (City, town, or county) Bountiful, Utah (State)

DATE REC'D BY LOCAL REG. Aug 2 1967
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Arthur Smith
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3066
Local Reg. No. 50
Reg. Dist. No. 380 391

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 200 Elmore 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 200
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 1345 East 4th North

3. NAME OF DECEASED (Type or Print)
a. (First): MRS. DIENA
b. (Middle): BERENDS
c. (Last): LEE

4. DATE OF DEATH (Month) (Day) (Year): July 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 6, 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Bortal, North Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Berends — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Frieda Emmens — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 502-05-1858-A
17. INFORMANT'S OWN SIGNATURE: Edwin Lee — ADDRESS: Mtn. Home, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 4, 1967, *to* July 7, 1967, *that I last saw the deceased alive on* July 7, 1967, *and that death occurred at* 11:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Malone R. Loebs MD 289
23b. ADDRESS: Mountain Home Idaho
23c. DATE SIGNED: 7-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/10/67
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Aug 2 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Verl Humphrey
LICENSE NO.: E-503

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

...rmant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 19 1973

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 15 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3067
Local Reg. No. 51
Reg. Dist. No. 380 391

BIRTH NO.

AUG 8 - 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 200 Elmore 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mt. Home

c. LENGTH OF STAY (in this place) 5 mo.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. Home Hospital DOA 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 200 b. COUNTY Elmore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mt. Home

d. STREET ADDRESS (If rural, give location) 1660 E. 5th St. No.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Heidi	Ann	McFall	July 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Single	January 18, 1967		5	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02	None	Walla Walla, Washington	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard W. McFall	Richmond, Calif.	Mary Law	Crothersville, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
None	None	Richard W. McFall	Mt. Home, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4927

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY CONGESTION & EDEMA — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Early, Acute Pneumonitis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation was last saw the deceased *alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur Smith 583	Coroner 4	Mountain Home, Idaho	7/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7/12/1967	DeWitt Funeral Home	Walla Walla, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 2 1967	T. Andrews	A. Del Humphreys	E-502

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3068
Local Reg. No. 52
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 200 Elmore 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Mem. Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 200
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 560 N. 4th E.

3. NAME OF DECEASED (Type or Print)
a. (First): CORA
b. (Middle): AKE
c. (Last): MONTGOMERY

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1967

5. SEX: Female
6. COLOR OR RACE: Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 12, 1900
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Ake — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Laura Ford — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: X Paul Montgomery — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 179X Carcinoma Breast — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1953, *to* July 12, 1967, *that I last saw the deceased alive on* July 12, 1967 *and that death occurred at* 10:03 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Malone W. Kelsch 289 (Degree or title) M.D.
23b. ADDRESS: Mtn. Town Home Idaho
23c. DATE SIGNED: July 26, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Aug 2 1967
REGISTRAR'S SIGNATURE: A. Andersen
25. EMBALMER: H. Neil Humphreys
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: Smith Mortuary

AUG 4 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3069
Local Reg. No. 53
Reg. Dist. No. 380 391

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Mem. Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 200
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): HATTIE
b. (Middle): V.
c. (Last): NORELL

4. DATE OF DEATH (Month) (Day) (Year): July 16, 1967

5. SEX: Femalr
6. COLOR OR RACE: Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 18, 1880
9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salem, Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James F. Shaner
BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Elenore Holiday
BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-36-1338 BX
17. INFORMANT'S OWN SIGNATURE: Byron M. Norell
ADDRESS: Route 4 Nampa Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Guy W. Wells 718 M.D. 1
23b. ADDRESS: Mtn. Home, Idaho
23c. DATE SIGNED: 7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/18/67
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Aug 2 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Neal Humphrey
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 9 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3070
Local Reg. No. 54
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Mem. Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Smiths Prairie, Idaho
d. STREET ADDRESS (If rural, give location): Box 58 Star Route A

3. NAME OF DECEASED (Type or Print): a. (First) ANNIE b. (Middle) ELIZABETH c. (Last) FELLOWS

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Cau.	Married 3	July 25, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife		Orderville, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Sumner Fackrell		Margaret Clarissa Handcock	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		×Ernest A Fellows	Prairie, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5795 Bowel obstruction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jay W. Wells 7/8 M.D.	Mountain Home, Idaho	7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/21/67	Mtn. View Cemetery	Mountain Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 2 1967	A Jackson	H Owl Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3071
Local Reg. No. 55
Reg. Dist. No. 380 391

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 200 Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Featherville
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Head of Jumbo Creek & Skeleton Creek

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 200
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Grand View
d. STREET ADDRESS (If rural, give location) Wood Creek Ranch

3. NAME OF DECEASED (Type or Print)
a. (First) ISIDERO
b. (Middle) 000
c. (Last) SUSAETA

4. DATE OF DEATH (Month) (Day) (Year) July 18, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH June 30, 1943
9. AGE (In years last birthday) 24 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheepherder 04
10b. KIND OF BUSINESS OR INDUSTRY Wood Creek Stock
11. BIRTHPLACE (State or foreign country) Co. Forua, Viscaya, Spain
12. CITIZEN OF WHAT COUNTRY? Spain

13. FATHER'S NAME Juan Susaeta — BIRTHPLACE Spain
14. MOTHER'S MAIDEN NAME ELeteria Malasechevarria — BIRTHPLACE Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Basilio Susaeta — ADDRESS Grand View, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9358

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Electricution — INTERVAL BETWEEN ONSET AND DEATH Instantly

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Struck by Lightning
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Mountains 09
21c. (CITY, TOWN, OR TOWNSHIP) 200 (COUNTY) (STATE) Rural - Featherville, Elmore, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 18, 1967 5:00 p.m. 2
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Struck by lightning while tending sheep on high ridge

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation only, *19___, to ___, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at ___ m., from the causes and on the date stated above.*

23a. SIGNATURE Arthur Smith 583 (Degree or title) Coroner 4
23b. ADDRESS Mountain Home, Idaho
23c. DATE SIGNED 7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7/26/67
24c. NAME OF CEMETERY OR CREMATORY Bilbao, Viscaya, Spain
24d. LOCATION (City, town, or county) (State) Bilbao, Viscaya, Spain

DATE REC'D BY LOCAL REG. Aug 2 1967
REGISTRAR'S SIGNATURE P. Sadesson
25. EMBALMER H. Neil Humphreys
LICENSE NO. E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3072

Local Reg. No.

Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 200 Elmore — AUG 18 1967 — Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hammett — c. LENGTH OF STAY (If this place) 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hammett — 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho — b. COUNTY Elmore 200

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hammett

d. STREET ADDRESS (If rural, give location) Hammett

3. NAME OF DECEASED (Type or Print) — a. (First) MRS. — b. (Middle) HANNAH EFFIE — c. (Last) HILTY

4. DATE OF DEATH (Month) (Day) (Year) July 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months	Days	If UNDER 24 HRS.: Hours	Min.
Female	White	Married 3	Nov. 13, 1887	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Harrisonburgh, Virginia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Cyrus Showalter	Virginia	Lydia Wenger	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		Carol Reeves	Hammett, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 2, 1946, *to* July 22, 1967, *that I last saw the deceased alive on* May 3, 1967, *and that death occurred at* 8:00 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. A. Parker	M.D.	Box 70 Glenns Ferry Ida	Aug 2, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/25/67	Glenn Rest Cemetery	Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 3 - 1967	Mary Sullivan	Arthur Smith	E-403

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Smith Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3073
Local Reg. No. 56
Reg. Dist. No. 380 391

BIRTH NO.

AUG 8 - 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 200 Elmore 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 290 So. 3rd East 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 200
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
d. STREET ADDRESS (If rural, give location) 290 So. 3rd East

3. NAME OF DECEASED (Type or Print)
a. (First) FRANK
b. (Middle) SAMUEL
c. (Last) MERRILL

4. DATE OF DEATH (Month) (Day) (Year) July 28, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH January 4, 1889
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Logger
10b. KIND OF BUSINESS OR INDUSTRY Timber Industry
11. BIRTHPLACE (State or foreign country) Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME D. F. Merrill — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Mary Stillwell — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War 13
16. SOCIAL SECURITY NO. 519-18-5657A
17. INFORMANT'S OWN SIGNATURE [signature] — ADDRESS Kellogg, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

350X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Parkinson's Disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1966, *to* July 28, 1967, *that I last saw the deceased alive on* June 20, 1967, *and that death occurred at* 9:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Malone W. Toelsch 289 (Degree or title) — **23b. ADDRESS** Mountain Home Idaho — **23c. DATE SIGNED** 8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/2/67
24c. NAME OF CEMETERY OR CREMATORY Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State) Mountain Home, Idaho

DATE REC'D BY LOCAL REG. Aug 2 1967
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Arthur Smith
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Smith Mortuary

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 21 1967 Bureau of Vital Statistics

State File No. 3074
Local Reg. No. 3
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 211 Franklin 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial Hospital 08

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 210
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Banida rural
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Lauritz
b. (Middle)
c. (Last) Gregersen

4. DATE OF DEATH (Month) (Day) (Year) July 2, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH August 16, 1894
9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Haven, Denmark
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Fredrick Lauritz — BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Maren Petrine Jorgensen — BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-60-4647
17. INFORMANT'S OWN SIGNATURE Marcus J. Gregersen — ADDRESS Preston Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic [illegible] — INTERVAL BETWEEN ONSET AND DEATH 5 yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Pulmonary Emphysema — 10 yrs; Cor Pulmonale — 5 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1960, *to* July 2 1967 *that I last saw the deceased alive on* July 1, 1967 *and that death occurred at* 6P *m., from the causes and on the date stated above.*

23a. SIGNATURE O. R. Cutler 122 (Degree or title) MVI
23b. ADDRESS Preston Idaho
23c. DATE SIGNED 7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Preston Cemetery
24d. LOCATION (City, town, or county) (State) Preston, Idaho

DATE REC'D BY LOCAL REG. 7-6-67
REGISTRAR'S SIGNATURE Eppie W. Brower
25. EMBALMER O. Sherwin Webb — LICENSE NO. 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WEBB FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3075
Local Reg. No. 4
Reg. Dist. No. 540

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 210 Franklin 182
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Treasureton
c. LENGTH OF STAY (in this place) life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at his home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 210
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Treasureton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Thomas
b. (Middle) Jefferson
c. (Last) Barger

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Jan. 24, 1885
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer 04
10b. KIND OF BUSINESS OR INDUSTRY agriculture
11. BIRTHPLACE (State or foreign country) Downey, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Abram L Barger — BIRTHPLACE Sidney, Iowa
14. MOTHER'S MAIDEN NAME Ellen Hunt — BIRTHPLACE San Bernardino, Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 721-14-2575
17. INFORMANT'S OWN SIGNATURE Pearl N Barger — ADDRESS Preston, Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic [illegible] — INTERVAL BETWEEN ONSET AND DEATH 5 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 16 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 15, 1967, *to* July 3, 1967, *that I last saw the deceased alive on* July 7, 1967, *and that death occurred at* 9 17 *m., from the causes and on the date stated above.*

23a. SIGNATURE O. R. Cutler 122 (Degree or title) MW
23b. ADDRESS Preston Idaho
23c. DATE SIGNED 7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 7, 1967
24c. NAME OF CEMETERY OR CREMATORY Treasureton Cemetery
24d. LOCATION (City, town, or county) (State) Treasureton, Idaho

DATE REC'D BY LOCAL REG. 7-7-1967
REGISTRAR'S SIGNATURE Eppie W. Brower
25. EMBALMER O. Sherwin Webb — LICENSE NO. 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WEBB FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3076
Local Reg. No. 5
Reg. Dist. No. 540

BIRTH NO. RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY 211 Franklin JUL 21 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston Bureau of Vital Statistics
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 580 South 1st East 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 211
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 580 South 1st East

3. NAME OF DECEASED (Type or Print)
a. (First) Ethel
b. (Middle) Warrick
c. (Last) Cole Stewart

4. DATE OF DEATH (Month) (Day) (Year) July 5, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 19, 1898
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Warrick, Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George W. Warrick — BIRTHPLACE Virginia
14. MOTHER'S MAIDEN NAME Rosamond Hall — BIRTHPLACE Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 14 9028
17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Preston Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive heart disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1965, *to* July, 1967, *that I last saw the deceased alive on* 7/3, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Leo R. Hawkes M.D. 214 (Degree or title)
23b. ADDRESS Preston, Idaho
23c. DATE SIGNED 7/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Preston Cemetery
24d. LOCATION (City, town, or county) (State) Preston, Idaho

DATE REC'D BY LOCAL REG. 7-10-67
REGISTRAR'S SIGNATURE Eggie W. Brower
25. EMBALMER O. Sherwin Webb — LICENSE NO. 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 17 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3077
Local Reg. No. 6
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 211 Franklin 515
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 15 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial Hospital 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 51 Wyoming
b. COUNTY: 555 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Afton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sarah Pearl
b. (Middle): Perry
c. (Last): Bowles

4. DATE OF DEATH (Month) (Day) (Year): July 14, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 12, 1888
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Lenape, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Flavious Perry — BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Arnetta E. Harman — BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Edward Bowles — ADDRESS: Afton, Wyoming

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture skull
ANTECEDENT CAUSES — Comp. Fracture of femur
Fracture of bd femur
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 30 min

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT XX (Specify) SUICIDE HOMICIDE
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 36 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 210 Franklin (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Car ran off road & turned over

22. *I hereby certify that I attended the deceased from* July 14, 1967, *to* July 14, 1967, *that I last saw the deceased alive on* Dean Morgan, 19__, *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: O. R. Cutler 122 (Degree or title) MD
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 17, 1967
24c. NAME OF CEMETERY OR CREMATORY: Afton Cemetery
24d. LOCATION (City, town, or county) (State): Afton Wyoming

DATE REC'D BY LOCAL REG.: 7-14-67
REGISTRAR'S SIGNATURE: Eppie W. Brower
25. EMBALMER: Sherwin Webb — Webb Funeral Home
LICENSE NO.: 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3078
Local Reg. No. 7
Reg. Dist. No. 540

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 9 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 21 Franklin 115
b. CITY OR TOWN (If outside corporate limits, write RURAL and township) Preston
c. LENGTH OF STAY (in this place) 15 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 32 North 2nd West 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 24
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 32 North 2nd West

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Andrew	Norell	Checketts	July 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	February 27, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Dairying	Providance, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George F. Checketts	England	Mary J. Taylor	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 34 0857	Dora G Checketts	Preston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Arteriosclerotic Heart Dis	6 yrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis	16 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Bronchial Asthma	16 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1967 *to* July 21, 1967 *that I last saw the deceased alive on* July 27, 1967, *and that death occurred at* 4 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. K. Cutler M.D.	Preston Idaho	7-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 1, 1967	Preston Cemetery	Preston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-7-1967	Eggie W. Brower	O. Sherwin Webb	316

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 18 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3079
Local Reg. No. 36
Reg. Dist. No. 660

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 22 / Fremont 309
b. CITY OR TOWN (If outside corporate limits, write township) St. Anthony
DURATION OF STAY (in this place) 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont Memorial Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 170 b. COUNTY Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Kilgore
d. STREET ADDRESS (If rural, give location) 1 mile east of Kilgore

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	FRED	ABNER	SMITH	July	3	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	August 11, 1883	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher, retired 04	Livestock	Shelbourne, Vermont	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Girdin Smith	No record	Mary Jane Unknown	No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-60-6781	Darrel L. Welch	Boise, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*	INTERVAL BETWEEN ONSET AND DEATH
(a)	Cerebro Vascular accident	36 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arterio Sclerosis Generalized	8 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Myocardial Infarction	9 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Townsend Fremont Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 19 67, *to* 7-3-67, 19___, *that I last saw the deceased alive on* 7-3-67, 19___, *and that death occurred at* 8:35 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M. D.	St. Anthony, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Juky 3, 1967	Spencer Cemetery	Spencer, Clark Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 6 67	[signature]	Orland C. Buck	E-250

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3080
Local Reg. No. 34
Reg. Dist. No. 651

BIRTH NO.

RECEIVED JUL 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 220 Fremont
b. CITY OR TOWN Ashton
c. LENGTH OF STAY (in this place) 3 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 45 Utah
b. COUNTY 555 Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salt Lake City, Utah
d. STREET ADDRESS (If rural, give location) Alta Club

3. NAME OF DECEASED (Type or Print)
a. (First) PAUL
b. (Middle) HINCKLEY
c. (Last) RAY

4. DATE OF DEATH (Month) July (Day) 4, (Year) 1967

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 2

8. DATE OF BIRTH Feb., 6, 1893

9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer 16

10b. KIND OF BUSINESS OR INDUSTRY Self- Employed

11. BIRTHPLACE (State or foreign country) Deseret, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Alexander Ray — BIRTHPLACE Mississippi

14. MOTHER'S MAIDEN NAME Minerva Hinckley — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE R. L. Forman, (by Phone) — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 12 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 July, 1967, *to* 4 July, 1967, *that I last saw the deceased alive on* 4 July, 19 67, *and that death occurred at* 7:02 P m., *from the causes and on the date stated above.*

23a. SIGNATURE W. A. Melcher (Degree or title) M.D. 352

23b. ADDRESS Ashton, Idaho

23c. DATE SIGNED 6 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 5 July 67

24c. NAME OF CEMETERY OR CREMATORY Salt Lake City, Utah

24d. LOCATION (City, town, or county) Salt Lake City, Utah (State)

DATE REC'D BY LOCAL REG. 8 July 67

REGISTRAR'S SIGNATURE M. L. Hansen

25. EMBALMER M. L. Hansen

LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 13 1967

AUG 21 1967

JAN 3 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3081
Local Reg. No. 33
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 220 Fremont — JUL 18 1967 — 530
b. CITY OR TOWN Parker — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 30 minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) OOD

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY 220 Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Newdale
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GODFREY		SCHWENDIMAN	July 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
~~Female~~ Male	Caucasian	Widowed 2	November 2, 1879	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cattleman and Farmer	04	Bern, Switzerland	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Schwendiman	Switzerland	Magdalena Stradhaur	Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.		518-52-3627	Mrs. L. E. Remington	Parker, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4339

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) none

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-1, 19 65, *to* 7-2, 19 67, *that I last saw the deceased alive on* 8-23, 19 66, *and that death occurred at* 11:30AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ray G. Mabey MD	Rexburg, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8 July 67	Teton-Newdale Cemetery	Sugar City, RFD#1, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER?	LICENSE NO.
July 67	M. L. Hansen	M. L. Hansen	E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3082
Local Reg. No. 37
Reg. Dist. No. 651

BIRTH NO.

RECEIVED JUL 20 1967 000 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 220 Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lamont
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rural 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 220
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Chester (Rural)
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): LOWELL
b. (Middle): EARNEST
c. (Last): HATHAWAY

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1967

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct., 5, 1912
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Ashton, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Wm. Hathaway — BIRTHPLACE: North Ogden, Utah
14. MOTHER'S MAIDEN NAME: Louisa Welker — BIRTHPLACE: Safford, Arizona

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 712-09-2219
17. INFORMANT'S OWN SIGNATURE: Dennis L. Hathaway — ADDRESS: Chester, Idaho

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombus, recent, R coronary artery

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis, severe, coronaries
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 746 (Degree or title) M.D. 1
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 13 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 17 July 67
24c. NAME OF CEMETERY OR CREMATORY: Wilford Cemetery
24d. LOCATION (City, town, or county) (State): St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG.: 17 July 67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

JUL 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 18 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3083
Local Reg. No. 4
Reg. Dist. No. 657

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 230 Fremont 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) His Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 410 b. COUNTY Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
d. STREET ADDRESS (If rural, give location) None Given

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	THOMAS	ALBERT	MURDOCK	July 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	28 Sept. 1942	24				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06		St. Anthony, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Reed C. Murdock	Farnum, Idaho	Ruth Grover	Parker, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
1 National Gaurd 0		X Reed Murdock	Ashton, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) celebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) gunshot — instant
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13	(COUNTY) 230	(STATE)
suicide 2	home 01	Ashton	Fremont	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
July	20	1967	8:30 P.m. 2		

22. *I hereby certify that I attended the deceased from* DOA X 2 *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 8:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul Connelly 583	Coroner 4	St. Anthony, Idaho	7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	25 July 1967	Pineview Cemetery	Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
3 August 67	M. L. Hansen	Robert A. Bean	E-456

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Bean Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: APR 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3084
Local Reg. No. 38
Reg. Dist. No. 650

Certificate of Death

STATE OF IDAHO

RECE'' AUG - 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 221 Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) North Fork Snake River 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 221
b. COUNTY Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) 445 No. Bridge

3. NAME OF DECEASED (Type or Print)
a. (First) BYRON
b. (Middle) M.
c. (Last) TIBBITTS SR.

4. DATE OF DEATH (Month) (Day) (Year) July 20, 1967

5. SEX Male
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH June 10, 1893
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Potato Packing Production 22
10b. KIND OF BUSINESS OR INDUSTRY Self-Employed
11. BIRTHPLACE (State or foreign country) Providence, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lorenzo E. Tibbitts, BIRTHPLACE Thompsonville, Conn.
14. MOTHER'S MAIDEN NAME Mary A. Marler, BIRTHPLACE Providence, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-38-9424
17. INFORMANT'S OWN SIGNATURE Clive M Tibbitts, ADDRESS St. Anthony, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suffocation due to drowning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Unknown 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) St. Anthonym Fremont, Idaho 13 221
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* D. O. A. *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Paul Romell 583 (Degree or title) Coroner 4
23b. ADDRESS St. Anthony, Idaho
23c. DATE SIGNED 23 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 25 July 67
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State) Idaho Falls, Bonneville, Idaho

DATE REC'D BY LOCAL REG. 25 July 67
REGISTRAR'S SIGNATURE M. L. Hansen
25. EMBALMER M. L. Hansen
LICENSE NO. E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3085
Local Reg. No. 37
Reg. Dist. No. 651

BIRTH NO.

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 220 Fremont 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Island Park- Rural
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U. S. Hiway 191 Henrys Lake Flat

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 03 b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1310 Willard

3. NAME OF DECEASED (Type or Print) a. (First) BOYD b. (Middle) H. c. (Last) MOSER

4. DATE OF DEATH (Month) (Day) (Year) July 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	Oct. 17, 1934	32		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Supervisor 09	Mt.States Tel.Co.	Auburn, Wyoming	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Evan O. Moser	Wyoming	Theo Hyde	Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXXX		Van Moser	Pocatello, Idaho

18. CAUSE OF DEATH 8764
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured Aorta,

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: instant

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13	(COUNTY) 220	(STATE)
accident	Highway 191 06	Island Park-Fremont		Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
7	23	67	10:30 P.M		Two car accident

22. *I hereby certify that I attended the deceased from* July 23, 67 *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul Connell	583 Coroner 4	POB 123 St Anthony	7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Jul.26,1967	Hillcrest Cemetery	Weiser, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
28 July 67	M.L. Hansen	M.L. Hansen	E-356

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 23 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 9 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2086
Local Reg. No. 4
Reg. Dist. No. 631

BIRTH NO.

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 220 Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural (Hery's Lake)
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060 b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) EUNICE b. (Middle) BROADHEAD c. (Last) HOWELL

4. DATE OF DEATH (Month) (Day) (Year): July 24, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: December 13, 1909

9. AGE (In years last birthday): 57 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Thomas, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jabez H. Broadhead BIRTHPLACE: LaVan, Utah

14. MOTHER'S MAIDEN NAME: Mary E. Peabody BIRTHPLACE: Salt Lake, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Eunice Howell ADDRESS: Aberdeen, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 24, 19 67, *to* ~~xxxx

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3087
Local Reg. No. 1
Reg. Dist. No. 340-341

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 231 Gem 117
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) 17 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 626 So. Johns 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 231 b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 626 So. Johns

3. NAME OF DECEASED (Type or Print)
a. (First) Rex b. (Middle) Eugene c. (Last) Eighme

4. DATE OF DEATH (Month) (Day) (Year) July 4, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married 1
8. DATE OF BIRTH Aug. 25, 1949
9. AGE (In years last birthday) 17 — IF UNDER 1 YEAR Months 10 Days 9 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 06
10b. KIND OF BUSINESS OR INDUSTRY auto
11. BIRTHPLACE (State or foreign country) Emmett, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME King Cecil Eighme — BIRTHPLACE Pittsville, Wisc.
14. MOTHER'S MAIDEN NAME Bertha Packer — BIRTHPLACE Pocatello, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-52-8854
17. INFORMANT'S OWN SIGNATURE X Bertha Burke — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9733

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) carbon monoxide poisoning — INTERVAL BETWEEN ONSET AND DEATH unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home 01
21c. (CITY, TOWN, OR TOWNSHIP) Emmett 13 (COUNTY) 231 Gem (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 7-4-67 5p m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the* ~~deceased~~ 2 *from* 2 *19* never *, to* ____, *19* ____, *that I last saw the deceased alive on* ____, *19* ____, *and that death occurred at* 5p *m., from the causes and on the date stated above.*

23a. SIGNATURE Glenn W Beatty — 583 (Degree or title) Coroner 4
23b. ADDRESS Emmett, Idaho
23c. DATE SIGNED July 4, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 1
24b. DATE July 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Emmett
24d. LOCATION (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. July 8, 1967
REGISTRAR'S SIGNATURE Jean A Beatty
25. EMBALMER Glenn W Beatty — LICENSE NO. E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3088
Local Reg. No. 2
Reg. Dist. No. 340-341

RECEIVED JUL 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 231 Gem — 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) W. K. Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 231 Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Route 1, box 469

3. NAME OF DECEASED (Type or Print)
a. (First) Henry
b. (Middle) --
c. (Last) Helmer

4. DATE OF DEATH (Month) (Day) (Year) July 19, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Jan. 25, 1894

9. AGE (In years last birthday) 73
IF UNDER 1 YEAR: Months 5 Days 24
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Transfer 17

10b. KIND OF BUSINESS OR INDUSTRY lumber

11. BIRTHPLACE (State or foreign country) Alexandradar, Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes
(If yes, give war or dates of service) WWI 3 1517

16. SOCIAL SECURITY NO. 518-07-3302

17. INFORMANT'S OWN SIGNATURE Mrs. L. E. Jones
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of Stomach
INTERVAL BETWEEN ONSET AND DEATH: 8 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 5/10/67

19b. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* July 19, 1967, *that I last saw the deceased alive on* July 19, 1967, *and that death occurred at* 2:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Ernest P Lawrence 429 (Degree or title)

23b. ADDRESS Emmett Ida

23c. DATE SIGNED 7/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE 7/24/67

24c. NAME OF CEMETERY OR CREMATORY Emmett Cemetery

24d. LOCATION (City, town, or county) Emmett, Idaho (State)

DATE REC'D BY LOCAL REG. July 25 1967

REGISTRAR'S SIGNATURE Jean A Beatty

25. EMBALMER Walter F Potter

LICENSE NO. E 445

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 26 2006

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3089
Local Reg. No. 3
Reg. Dist. No. 340-341

RECEIVED JUL 27 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 231 Gem — 202
b. CITY OR TOWN Emmett — LENGTH OF STAY (in this place) 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION East Main St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 231 b. COUNTY Gem
c. CITY OR TOWN Emmett
d. STREET ADDRESS (If rural, give location) East Main St.

3. NAME OF DECEASED (Type or Print): a. (First) Henry b. (Middle) Frederick c. (Last) Baisch

4. DATE OF DEATH (Month) (Day) (Year): July 20, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: Aug. 8, 1897

9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR Months: 11 Days: 12 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Palisade, Colorado

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frederick Baisch — BIRTHPLACE: Mascoutah, Ill.

14. MOTHER'S MAIDEN NAME: Anna Katherine Hottes — BIRTHPLACE: Mascoutah, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-44-5224

17. INFORMANT'S OWN SIGNATURE: William H. Baisch — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PROBABLE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: DEAD ON ARRIVAL

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 9 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ronald P. Kawhorn 429 (Degree or title) — **23b. ADDRESS**: Emmett Ida — **23c. DATE SIGNED**: 7/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial — **24b. DATE**: July 25, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Emmett Cemetery — **24d. LOCATION** (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: July 24, 1967 — REGISTRAR'S SIGNATURE: Jean A. Beatty

25. EMBALMER: Walter Potter — LICENSE NO.: E 445

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3090
Local Reg. No. 4
Reg. Dist. No. 340, 341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 23 / Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shady Lane Nursing Home 26

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 23 / Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Shady Lane Nursing Home 5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Gertrude		Wakefield	July 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
female	white	widowed 2	Sept. 16, 1886	80	9	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE 07	---	Prairie City, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hal Miller		Marion Hess	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-60-1483T		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4221

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Disease years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-1 19[illegible] *to* 7-24, 19 67, *that I last saw the deceased alive on* 6-20, 19 66, *and that death occurred at* 11:55 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Hanna E. Holverson MD 241 (Degree or title)	Emmett, Idaho	8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 28, 1967	Sweet	Sweet, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 9, 1967	Jesse A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

6

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3091
Local Reg. No. 5
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 231 Gem 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 231
b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print)
a. (First) Myrtle
b. (Middle)
c. (Last) Standley

4. DATE OF DEATH (Month) (Day) (Year) July 30, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH March 29, 1895
9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Bogard, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Miles — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Lulu Smith — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-56-7000
17. INFORMANT'S OWN SIGNATURE X Boyd K. Standley — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

465X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary emboli & mesenteric thrombosis — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1950 *to* _____, 1967, *that I last saw the deceased alive on* 31 July, 1967, *and that death occurred at* 9:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE J. A. Goodman, M.D. (Degree or title) 184
23b. ADDRESS Emmett, Ida.
23c. DATE SIGNED 1 Aug. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Aug. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY Emmett
24d. LOCATION (City, town, or county) Emmett Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 1, 1967
REGISTRAR'S SIGNATURE Jean W. Beatty
25. EMBALMER Glenn W. Beatty
LICENSE NO. E392

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: The Beatty Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 8 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 8 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3092
Local Reg. No. 2991
Reg. Dist. No. 420

RECEIVED JUL 21 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 240 Gooding
b. CITY OR TOWN Gooding
c. LENGTH OF STAY IN PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION Gooding County Hospital 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 240 Gooding
c. CITY OR TOWN Gooding
d. STREET ADDRESS (If rural, give location) 625 4th Av. W.

3. NAME OF DECEASED (Type or Print)
a. (First) Letty
b. (Middle)
c. (Last) Stone

4. DATE OF DEATH (Month) (Day) (Year) July 7, 1967

5. SEX Female

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Aug. 24, 1884

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Fisher, Minn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John A. Bryson
BIRTHPLACE Canada

14. MOTHER'S MAIDEN NAME Isabelle McDonald
BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT'S OWN SIGNATURE Frank D Stone
ADDRESS Gooding Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia
INTERVAL BETWEEN ONSET AND DEATH 4-5 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility and Gen. Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1 '67, 19___, *to* July 7, 1967, *that I last saw the deceased alive on* July 6, 1967, *and that death occurred at* 5:03 Am., *from the causes and on the date stated above.*

23a. SIGNATURE Marvin V. Klemptner (Degree or title) MD
23b. ADDRESS Gooding, Idaho
23c. DATE SIGNED July 19, '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) (State) Gooding, Gooding, Idaho

DATE REC'D BY LOCAL REG. 7-20-67
REGISTRAR'S SIGNATURE Faleen L Meyer

25. EMBALMER
LICENSE NO. E-343

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

JUN 2 9 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3093
Local Reg. No. 2972
Reg. Dist. No. 420

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 240 Gooding 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerman
c. LENGTH OF STAY (If this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Residence in Hagerman 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240 b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerman
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Carl	Wayne	Greman	July	10	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	July 13, 1913	53				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dept. of State of
10b. KIND OF BUSINESS OR INDUSTRY Ida. Highways.
11. BIRTHPLACE (State or foreign country) Cnthon, Iowa
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
E. E. Greman	Iowa	Minnie F. Gambs	Iowa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None 485-16-4609
17. INFORMANT'S OWN SIGNATURE X Robert L Meyer ADDRESS from Thompson Chapel records.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 5 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) angina pectoris — 2 mon
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* 10 Jul, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard L Thomas MD	Gooding Idaho	13 Jul 67

24a. BURIAL ☐ CREMATION ☐ REMOVAL ☐ (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
7-14-1967	7-14-1967	Buhl Cemetery	Buhl Twin Falls, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-20-67	Robert L Meyer	Robert L Meyer	E-424

FIRM NAME Thompson Chapel Gooding, Idaho.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 26 1967 Bureau of Vital Statistics

State File No. 3094
Local Reg. No. 2973
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 240 GOODING 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WENDELL
c. LENGTH OF STAY (in this place) 3 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MAGIC VALLEY MANOR 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 240 GOODING
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) GOODING
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) SAULESBERRY
b. (Middle) RAY
c. (Last) GATES

4. DATE OF DEATH (Month) (Day) (Year) JULY 10, 1967

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2

8. DATE OF BIRTH Dec 13 1886

9. AGE (In years last birthday) 80
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR 04

10b. KIND OF BUSINESS OR INDUSTRY AGG.

11. BIRTHPLACE (State or foreign country) KANSAS

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME SALISBURY GATES
BIRTHPLACE KANSAS

14. MOTHER'S MAIDEN NAME ELIZABETH ?
BIRTHPLACE KANSAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 524-12-4179

17. INFORMANT'S SIGNATURE Irdah Redmond
ADDRESS Portland 3 Ore 8008 Tamphire

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 331X Cerebral Vascular Accid — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 20 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9 Jul, 1967, *to* 10 Jul, 1967, *that I last saw the deceased alive on* 9 Jul, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Leland Simmons 373 (Degree or title)

23b. ADDRESS Gooding, Idaho

23c. DATE SIGNED 16 Jul 67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 7/14/1967

24c. NAME OF CEMETERY OR CREMATORY WENDELL

24d. LOCATION (City, town, or county) GOODING CO. (State) IDAHO.

DATE REC'D BY LOCAL REG. 7-22-67

REGISTRAR'S SIGNATURE Robert S. Meyer

25. EMBALMER J. Forest Weaver

LICENSE NO. E353

FIRM NAME: Weaver Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3095
Local Reg. No. 2974
Reg. Dist. No. 420

RECEIVED JUL 26 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gooding 240 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
c. LENGTH OF STAY IN (If this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 243 COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Melvin b. (Middle) Giles c. (Last) Parks

4. DATE OF DEATH (Month) (Day) (Year) July 15 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Oct. 2, 1883

9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Bushnell, South DaKota.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Martin Parks BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Delia Turner BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None 475X

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE ADDRESS
X Mrs. Walter Prince Gooding, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute upper resp infection — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 27, 1959, to July 15, 1967, that I last saw the deceased alive on July 15, 1967, and that death occurred at 5:30, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Maurice E Scheel MD

23b. ADDRESS Wendell, Idaho

23c. DATE SIGNED 7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-18-1967

24c. NAME OF CEMETERY OR CREMATORY Hagerman Cemetery

24d. LOCATION (City, town, or county) (State) Hagerman Gooding Idaho

DATE REC'D BY LOCAL REG. July 22-67

REGISTRAR'S SIGNATURE Robert S Meyer

25. EMBALMER Robert S Meyer

LICENSE NO. E- 434

FIRM NAME: Thompson Chapel Gooding, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED JUL 27 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3096
Local Reg. No. 2975
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240 — 000
b. CITY OR TOWN: Wendell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — 16
b. COUNTY: Elmore — 039
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 1220 N. 6th E.

3. NAME OF DECEASED (Type or Print): a. (First) EMMA — b. (Middle) STONE — c. (Last) BARRY

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1967

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Feb. 28, 1885

9. AGE (In years last birthday): 82 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Clarion, Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Stone — BIRTHPLACE: Wisconsin

14. MOTHER'S MAIDEN NAME: Alma Braydon — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: —

17. INFORMANT'S OWN SIGNATURE: Maude Mound — ADDRESS: Rte Home

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Generalized Arteriosclerosis — 5 yrs

DUE TO (c) Cranium — 3yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Old-age

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 5-25, 1967 *to* death, 19___, *that I last saw the deceased alive on* 7-5, 1967, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold G. Holmgren M.D. 240 — **23b. ADDRESS**: Wendell, Ida. — **23c. DATE SIGNED**: 7-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 7/19/67 — **24c. NAME OF CEMETERY OR CREMATORY**: Mtn. View Cemetery — **24d. LOCATION** (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: 7-24-67 — **REGISTRAR'S SIGNATURE**: Hallett Meyer — **25. EMBALMER**: H. Neil Humphreys — **LICENSE NO.**: E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3097
Local Reg. No. 2776
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240 — AUG 1 0 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell — Bureau of Vital Statistics — LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Manor 263

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 427 — b. COUNTY: T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 287 Van Buren Street

3. NAME OF DECEASED (Type or Print): a. (First) GLENN — b. (Middle) BENJAMIN — c. (Last) CLAMPITT

4. DATE OF DEATH: (Month) (Day) (Year): July 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	March 11, 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Stillwater, Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank A. Clampitt — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Ruth Ann Hirsh — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-12-8186
17. INFORMANT'S OWN SIGNATURE: Mrs Alpha Mae Clampitt — ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute emphysema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. coronary insuff.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-4-60, 19__, *to* 7/25/, 1967, *that I last saw the deceased alive on* 7-24-67, 19__, *and that death occurred at* 3:30 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Maurice E. Scheel M.D.	Wendell, Idaho	7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/28/67	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-31-67	Robert L. Meyer	Paul E. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 8 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

6 5

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

State File No. 3098
Local Reg. No. 2977
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 240 GOODING 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): HAGERMAN
c. LENGTH OF STAY (in this place): 3 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOME 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 240 GOODING
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): HAGERMAN RURAL
d. STREET ADDRESS (If rural, give location): So. E.

3. NAME OF DECEASED (Type or Print)
a. (First): REID
b. (Middle): E
c. (Last): COBLE

4. DATE OF DEATH (Month) (Day) (Year): JULY 26, 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: OCT. 9, 1916
9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CMDR. 05
10b. KIND OF BUSINESS OR INDUSTRY: NAVY
11. BIRTHPLACE (State or foreign country): HENDERSONVILLE N.C.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: WM. COBLE — BIRTHPLACE: N.C.
14. MOTHER'S MAIDEN NAME: DESSIE KEISLER — BIRTHPLACE: N.C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW 11 9
16. SOCIAL SECURITY NO.: 245-60-8421
17. INFORMANT'S OWN SIGNATURE: Mrs Reid E. Coble — ADDRESS: R1. Hagerman Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-19, 1965, *to* 7-26, 1967, *that I last saw the deceased alive on* 7-26, 1967, *and that death occurred at* 1:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Maurice E. Scheel MD 457 (Degree or title)
23b. ADDRESS: Wendell Ida
23c. DATE SIGNED: 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 7/31/1967
24c. NAME OF CEMETERY OR CREMATORY: HAGERMAN
24d. LOCATION (City, town, or county) (State): GOODING CO. IDAHO.

DATE REC'D BY LOCAL REG.: 8-4-67
REGISTRAR'S SIGNATURE: Lolee S. Meyer
25. EMBALMER: J. Forrest Weaver — LICENSE NO.: E 353
FIRM NAME: Weaver mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

12

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3099
Local Reg. No. 2979
Reg. Dist. No. 420

BIRTH NO.

AUG 10 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 240 GOODING
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TUTTLE
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HYWAY 1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 240 GOODING
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WENDELL
d. STREET ADDRESS (If rural, give location) RURAL SO W.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DELMAR	N	HENSLEE	JULY 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
M	W	MARRIED 3	JULY 22, 1912	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER 04	AGG.	CHADRICK MISSOURI	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
WM. W. HENSLEE	MISSOURI	IDA TABOR	MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519-10-6899	Sandra Robinson	Wendell Idaho

18. CAUSE OF DEATH 8254

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Head and Chest Injuries — INTERVAL BETWEEN ONSET AND DEATH: ½ Hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident 1	Highway 86	Wendell 13	Gooding 240	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
7 27 67 8.40 PM	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Automobile Accident

22. *I hereby certify that I attended the deceased from* x 2, 19, 19 x, 19, *that I last saw the deceased alive on* x, 19, *and that death occurred at* 9.20 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Milford Callen 588	Justice of the Peace 5	Wendell, Idaho	8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	7/31/1967	HAGERMAN	GOODING CO. IDAHO.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Irene S. Meyer	ROBERT MEYER	E-424

FIRM NAME: Weaver mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 9 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

#6

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 10 1967 Bureau of Vital Statistics

State File No. 3100
Local Reg. No. 2978
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 240 GOODING 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): TUTTLE
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HYWAY 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 240 GOODING
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WENDELL
d. STREET ADDRESS (If rural, give location): RURAL SO.W.

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERTA
b. (Middle): RASH
c. (Last): HENSLEE

4. DATE OF DEATH (Month) (Day) (Year): JULY 27 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: MAY 9.1916
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE 01
10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (State or foreign country): TURNER IDAHO.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: HENRY RASH — BIRTHPLACE: UTAH
14. MOTHER'S MAIDEN NAME: ELIZBETH THOMPSON — BIRTHPLACE: UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-32-3464
17. INFORMANT'S OWN SIGNATURE: Sandra Robinson — ADDRESS: Wendell Idaho Rt 1

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Broken Neck and Chest Injuries — INTERVAL BETWEEN ONSET AND DEATH: instantly

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Automobile Accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Wendell 13 Gooding 240 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 27 67 8.40 P
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Automobile Accident

22. *I hereby certify that I attended the deceased from* x 2, 19__, *to* x 2, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 8.40 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Mildred Callere 588 Justice of the Peace
23b. ADDRESS: 5 Wendell, Idaho
23c. DATE SIGNED: 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 7/31/1967
24c. NAME OF CEMETERY OR CREMATORY: HAGERMAN
24d. LOCATION (City, town, or county) (State): GOODING CO. IDAHO.

DATE REC'D BY LOCAL REG.: 8-4-67
REGISTRAR'S SIGNATURE: Robert S. Meyer
25. EMBALMER: J. Forrest Weaver — LICENSE NO.: E 353
FIRM NAME: Weaver Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 17 1967

APR 16 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

C.G. Barnes

Certificate of Death

STATE OF IDAHO

State File No. 3101
Local Reg. No. 2922
Reg. Dist. No. 420

BIRTH NO.

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN Tuttle
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Malad Canyon 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 270
d. STREET ADDRESS (If rural, give location) Route#2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Edward	Gene	Barnes	July 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 17, 1932	35				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Della Barnes	Cove, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-34-2285
17. INFORMANT'S OWN SIGNATURE Della Thompson ADDRESS Jerome, Idaho

8254

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiply head and Chest injuries — INTERVAL BETWEEN ONSET AND DEATH: Instantly

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 1 Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 12 canyon
21c. (CITY, TOWN, OR TOWNSHIP) 13 Tuttle (COUNTY) 240 Gooding (STATE) Idaho
21d. TIME OF INJURY (Month) 7 (Day) 30 (Year) 67 (Hour) 6.30
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Automobile accident

22. *I hereby certify that I attended the deceased from* ✕, 19__, *to* ✕, 19__, *that I last saw the deceased alive on* ✕, 19__, *and that death occurred at* 6:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Mildred Callen 588 5	Justice of the Peace	Wendell, Idaho	8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 3, 1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 8 1967	Helen S. Meyer	Robert L. Meyer	E-424

FIRM NAME: Thompson Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3102
Local Reg. No. 35
Reg. Dist. No. 240

RECEIVED JUL 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 250 Idaho 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
c. LENGTH OF STAY (in this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Grangeville General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kamiah 310
d. STREET ADDRESS (If rural, give location) Kamiah Hotel

3. NAME OF DECEASED (Type or Print) a. (First) MILO b. (Middle) E 092 c. (Last) WOOD

4. DATE OF DEATH (Month) (Day) (Year) July 5, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Jan 23, 1882

9. AGE (In years last birthday) 75
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Moscow, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jefferson Wood
BIRTHPLACE Monrovia, Iowa

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ~~None~~ 548-42-0662

17. INFORMANT'S OWN SIGNATURE Nettie M Brown
ADDRESS Kamiah, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7944 Complications of age — INTERVAL BETWEEN ONSET AND DEATH 7 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November, 1966, *to* July 5, 1967, *that I last saw the deceased alive on* July 5, 1967, *and that death occurred at* 2:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE 373 Wm Morrison MD (Degree or title)

23b. ADDRESS Grangeville, Id.

23c. DATE SIGNED July 19, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/8/1967

24c. NAME OF CEMETERY OR CREMATORY Kamiah

24d. LOCATION (City, town, or county) Kamiah, Idaho (State)

DATE REC'D BY LOCAL REG. July 14 1967

REGISTRAR'S SIGNATURE Irma Cone

25. EMBALMER Robert H. Hansen

LICENSE NO. E 433

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 10 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 31 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 25 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3108
Local Reg. No. 36
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 321
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Hill Nursing Home 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville 250
d. STREET ADDRESS (If rural, give location): Rt # 2 Box 48

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ALBERT	ALOYSIS	GEIGER	July 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	July 7, 1890	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hosp. Administrator 56	Hospital	Rock Island, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Geiger	New Orleans, La.	Margaret Rueth	Milwaukee, Wisconson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW#1 3	562 50 4985	Dora Geiger RH	Grangeville, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: immed.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Coronary atherosclerosis — several years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* about 1963, *to* 7 July, 1967, *that I last saw the deceased alive on* 30 June, 1967, *and that death occurred at* 7:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Waltman 487	M.D.	Grangeville, Idaho	13 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/10/67	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 17 1967	Irma Cone	Robert Hansen Robert Hansen	E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

JUL 26 1967

JUL 22 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3104
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

250 JUL 26 1967 109

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah Rural
LENGTH OF STAY (in this place): 9 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 3 miles East of Kamiah

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah, Idaho 250
d. STREET ADDRESS (If rural, give location): 3 Miles East of Kamiah.

3. NAME OF DECEASED (Type or Print): a. (First) ELMER b. (Middle) J c. (Last) GENTRY

4. DATE OF DEATH (Month) (Day) (Year): July 13, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 27, 1911

9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Keutterville, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rufus L Gentry — BIRTHPLACE: North Carolina

14. MOTHER'S MAIDEN NAME: Margaret Bledsoe — BIRTHPLACE: North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 01 1225

17. INFORMANT'S OWN SIGNATURE: Kenneth D Gentry — ADDRESS: Kamiah, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1967

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 8 MOS.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 652 (Degree or title) — 23b. ADDRESS: Kamiah, Idaho — 23c. DATE SIGNED: 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 7/17/67 — 24c. NAME OF CEMETERY OR CREMATORY: Kamiah — 24d. LOCATION (City, town, or county) (State): Kamiah, Idaho

DATE REC'D BY LOCAL REG.: 7/21/67 — REGISTRAR'S SIGNATURE: Viola V. Paul

25. EMBALMER: Robert R. Hansen — LICENSE NO.: E 433

FIRM NAME: Leep.

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

JUL 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 30 1984

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3105
Local Reg. No. 37
Reg. Dist. No. 240

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

JUL 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville 250
d. STREET ADDRESS (If rural, give location): 404 North A Street

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Franklin
c. (Last): Rankin

4. DATE OF DEATH (Month) (Day) (Year): July 14, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: March 27, 1876
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumbering 17
10b. KIND OF BUSINESS OR INDUSTRY: retired
11. BIRTHPLACE (State or foreign country): Miami County, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: John W. Rankin — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Asenatha Tuttle — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 26 6463
17. INFORMANT'S OWN SIGNATURE: Mrs Emma Pine — ADDRESS: Benicia, Calif

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Standstill

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): 2° to Severe Pneumonia
DUE TO (c): + senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 9 P. m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 621 Milton Hill Wiltse, M.D.
23b. ADDRESS: Grangeville, Ida.
23c. DATE SIGNED: 18 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/18/67
24c. NAME OF CEMETERY OR CREMATORY: Enterprise, Oregon
24d. LOCATION (City, town, or county) (State): Enterprise, Oregon

DATE REC'D BY LOCAL REG.: July 21, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert Hansen
LICENSE NO.: E433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3106
Local Reg. No. 10
Reg. Dist. No. 242

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: (Lewis) IDAHO — 250 — AUG 11 1967 — 202
b. CITY OR TOWN: Cottonwood — LENGTH OF STAY (in this place): 11 wks

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Lewis
c. CITY OR TOWN: Craigmont — 310
d. STREET ADDRESS (If rural, give location): Rt # 2

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Maries (St. Mary's) 093

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ZILPHA	E	MELCUM	July 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widdowed 2	July 1, 1878	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife 01	Farming	Dayton, Washington	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward James Stearns	Ohio	Lydia Ann Crabb	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-54-0079JI	Bertle L. Melcum	Craigmont, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4467 Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Chronic Hypertensive Cardio Vascular Renal — 10 yrs.
DUE TO (c) Generalized Arterio Sclerosis — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic Hypertrophic Arthritis — ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 24, 1967, *to* July 16, 1967, *that I last saw the deceased alive on* July 16, 19 67, *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
K. H. Collins 100	M D	Cottonwood, Idaho	7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	July 19, 1967	Normal Hill	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 19, 1967	Wesley J. Orr M.D. by m	K. H. Malcom	E 376

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3107
Local Reg. No. 38
Reg. Dist. No. 240

BIRTH NO.

AUG 11 1967
3-14
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 250 Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kamiah 310
d. STREET ADDRESS (If rural, give location) Kamiah

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) PETER c. (Last) MOORE

4. DATE OF DEATH (Month) (Day) (Year) July 23, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 30 1883

9. AGE (In years last birthday) 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) LaGrande, Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Moore
BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Alice Saleing
BIRTHPLACE LaGrande, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW # 1

16. SOCIAL SECURITY NO. 519 01 3916

17. INFORMANT'S OWN SIGNATURE Ada Moore
ADDRESS Kamiah, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 177X Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 2 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1967, to July 23, 1967 that I last saw the deceased alive on July 22 1967, and that death occurred at 12:00A m., from the causes and on the date stated above.

23a. SIGNATURE 373 (Degree or title) Wm Harrison MD
23b. ADDRESS Grangeville, Id.
23c. DATE SIGNED 7/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/27/67
24c. NAME OF CEMETERY OR CREMATORY Kamiah
24d. LOCATION (City, town, or county) Kamiah, Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 8, 1967
REGISTRAR'S SIGNATURE Irma Cone
25. EMBALMER Robert R Hansen
LICENSE NO. E 433
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3108
Local Reg. No. 11
Reg. Dist. No. 242

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Idaho 250 — AUG 11 1967 — 310 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood — LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood 250
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Frank	M.	Jenny	July	26	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	white	married 3	April 24 1904	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tavern owner 22
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cottonwood, Idaho
12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Jacob F. Jenny — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Anna Kees — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 36 4516
17. INFORMANT'S OWN SIGNATURE: Mrs Frank Jenny — ADDRESS: Cottonwood

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 5021 Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Pulm Atelectasis Pneumonia — 10 days
DUE TO (c): Severe Chronic Bronchitis — 2 Months

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Arteriosclerosis - Chronic

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF ~~OPERATION~~: Bronchial Asthma
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-23, 1967, *to* 7-26, 1967, *that I last saw the deceased alive on* July 26, 1967, *and that death occurred at* 7:00 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: W F. Orr MD (Degree or title): 399
23b. ADDRESS: Cottonwood, Idaho
23c. DATE SIGNED: July 29, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 29 67
24c. NAME OF CEMETERY OR CREMATORY: Catholic
24d. LOCATION (City, town, or county) (State): Cottonwood Idaho

DATE REC'D BY LOCAL REG.: July 29, 1967
REGISTRAR'S SIGNATURE: Theresa D. Orr, MD
25. EMBALMER: Gilbert Aldous
LICENSE NO.: E 421
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

MAR 5 1968

JUN 20 1974

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

State File No. 3109
Local Reg. No. 39
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Idaho 250 — AUG 1 1 1967 — 301
b. CITY OR TOWN: Grangeville — c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hosp. 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia 250
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Frederick	Blaine	Gilmore	July	31	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	white	Widowed 2	July 20 1883	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Cattle ranch	Sightly Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lyman W. Gilmore	Maine	Sarah A. Brown	Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			H. G. Gilmore	392 S.E. Third Toledo, Ore.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Perforated gall bladder — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Common duct stones — year

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Atrial fibrillation — ?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7/31/67	Bile peritonitis common duct stones	YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—	—	—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* July 30, 1967, *to* July 31, 1967, *that I last saw the deceased alive on* July 31, 1967, *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 444	MD	Grangeville, Idaho	8/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 3, 1967	Prairie View	Grangeville Idaho Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 8, 1967	Irma Cone	Robert A. Hansen	E433

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 1 0 1990

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person, WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Norman Hall

Certificate of Death

STATE OF IDAHO

State File No. 3110
Local Reg. No. 1
Reg. Dist. No. 640

BIRTH NO.

RECE JUL 24 1967 Bureau of Vital Statistics

1. PLACE OF DEATH — a. COUNTY: Jefferson 260 4-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bill Anderson Farm-Hamer
LENGTH OF STAY (in this place): hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Jefferson Co. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho 101
d. STREET ADDRESS (If rural, give location): 938 Payne

3. NAME OF DECEASED (Type or Print): a. (First) Byron b. (Middle) Eugene c. (Last) Leigh
4. DATE OF DEATH (Month) (Day) (Year): July 1, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Jan. 1, 1948
9. AGE (In years last birthday): 19 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Pump
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Byron Leigh — BIRTHPLACE: Malad, Idaho
14. MOTHER'S MAIDEN NAME: Ardeth Crawford — BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-52-9291
17. INFORMANT'S OWN SIGNATURE: Byron E. Leigh — ADDRESS: St Anthony

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Electrocution
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): accidently coming in contact with a 7000 Volt line.
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Inst.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Farm
21c. (CITY, TOWN, OR TOWNSHIP): Hamer 13 (COUNTY): 260 Jefferson (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 1, 1967 m.
21e. INJURY OCCURRED: WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: contacted high voltage line

22. *I hereby certify that I attended the deceased from* XXXX

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3111
Local Reg. No. 2
Reg. Dist. No. 640

RECEIVED
JUL 24 1967
Bureau of Vital Statistics

BIRTH NO. 260 174

1. PLACE OF DEATH
a. COUNTY: Jefferson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Annis
LENGTH OF STAY (in this place): 74 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rte. #1 Lorenzo,,Idaho.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Annis 260
d. STREET ADDRESS (If rural, give location): Rte. #1 Lorenzo, Idaho.

3. NAME OF DECEASED (Type or Print)
a. (First): ALBERT
b. (Middle): MARTIN
c. (Last): FISHER

4. DATE OF DEATH: July 18, 1967

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Nov. 17, 1892

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Annis, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oliver Cowdery Fisher
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Alice Angeline Richardson
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-24-2404

17. INFORMANT'S OWN SIGNATURE: Martha A. Fisher
ADDRESS: Lorenzo, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Emphysema, Chronic — 2 years
DUE TO (c): Asthma, Chronic — 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: None performed

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-9, 1952, *to* 18 July, 1967, *that I last saw the deceased alive on* 18 July, 1967, *and that death occurred at* 11:15 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Hall 522 (Degree or title): M.D.

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED: 20 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 21, 1967

24c. NAME OF CEMETERY OR CREMATORY: Little Butte

24d. LOCATION (City, town, or county) (State): Annis Jefferson Idaho.

DATE REC'D BY LOCAL REG.: 21 July 1967

REGISTRAR'S SIGNATURE: Mrs A B Eckersell

25. EMBALMER: Bruce A. Eckersell
LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3112
Local Reg. No. 4
Reg. Dist. No. 640

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH — 260 AUG 18 1967
a. COUNTY: Jefferson 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Roberts
LENGTH OF STAY (in this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Roberts 260
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Keith	Strong	Dodge	July	28	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	August 2, 1905	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Ucon, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Monroe Dodge	New York	Mary Lodema Strong	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Feb. 1924-Aug. 1924	518 07 7186	Rachel Dodge-Roberts, Ida	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asthma and emphysema, — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

and arteriolosclerotic heart disease.

DUE TO (b) Peptic ulcer

DUE TO (c) Rheumatoid arthritis.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-17-, 1963, *to* 7-28-, 1967, *that I last saw the deceased alive on* 7-6-, 1967, *and that death occurred at* 2:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John S Slater M D 210	Idaho Falls, Idaho	8/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/2/67	Ucon Cemetery	Ucon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/8/67	Mrs A D Eckersley	Ralph M. Wood Ralph Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3113
Local Reg. No. 3
Reg. Dist. No. 640

RECEIVED AUG 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 260 Jefferson
b. CITY OR TOWN: Clark
c. LENGTH OF STAY (in this place): 4 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION: Carson Nursing Home 097

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson
c. CITY OR TOWN: Roberts 260
d. STREET ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) LEROY c. (Last) JONES

4. DATE OF DEATH (Month) (Day) (Year): July 30, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Nov. 10, 1891

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Pocotaligo, W. Virginia.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Lewis Jones — BIRTHPLACE: W. Virginia

14. MOTHER'S MAIDEN NAME: Mary Susan Brightwell — BIRTHPLACE: W. Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or date of service): W.W.I 3

16. SOCIAL SECURITY NO.: 518-05-9106

17. INFORMANT'S OWN SIGNATURE: Reid L. Jones — ADDRESS: Roberts, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4280

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — years

DUE TO (c): Parkinson's Disease — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 29, 1962, *to* July 29 1967, *that I last saw the deceased alive on* July 29 1967, *and that death occurred at* 6:55P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Hall, 522 (Degree or title): M.D.

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED: 1 Aug. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 3, 1967

24c. NAME OF CEMETERY OR CREMATORY: Little Butte

24d. LOCATION (City, town, or county) (State): Annis Jefferson Idaho

DATE REC'D BY LOCAL REG.: 1 Aug 67

REGISTRAR'S SIGNATURE: Mrs A B Eckersell

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3114
Local Reg. No. 1003
Reg. Dist. No. 440

BIRTH NO.

RECEIVED JUL 7 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural)
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. 4 (7 mi E 3/4 N) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) 270
d. STREET ADDRESS (If rural, give location) Rt. 4

3. NAME OF DECEASED (Type or Print)
a. (First) Joseph
b. (Middle) Michael
c. (Last) Loucks

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH May 6, 1965

9. AGE (In years last birthday) 2
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02

10b. KIND OF BUSINESS OR INDUSTRY at home

11. BIRTHPLACE (State or foreign country) Moscow, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert R. Loucks
BIRTHPLACE Idaho

14. MOTHER'S MAIDEN NAME Ann Louise Olson
BIRTHPLACE Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. —

17. INFORMANT'S OWN SIGNATURE X Robert R. Loucks
ADDRESS Jerome, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Drowned — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Canal

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 270 Jerome Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 19—, *to* —, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 9:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 385 Coroner

23b. ADDRESS Jerome

23c. DATE SIGNED 5 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 6, 1967

24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery

24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. July 10 1967

REGISTRAR'S SIGNATURE Louella M. Deherr

25. EMBALMER W. L. Hove

LICENSE NO. E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3115
Local Reg. No. 1004
Reg. Dist. No. 440

BIRTH NO.

RECEIVED JUL 7 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural)
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. 3 (residence) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) 270
d. STREET ADDRESS (If rural, give location) Rt. 3

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CLAUDE	ARTHUR	SCOTT	July 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 22, 1899	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Cedar Falls, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fred A. Scott	unknown	Mary Nettler	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 36 7000	X Mrs. Ethel I. Scott	Rt. 3, Jerome, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: unk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* none *to* ____, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* 7:45 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. M. Nehrer M.D. Coroner	Jerome	10 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 10, 1967	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10, 1967	Lowella M. Nehrer	Wilbur L. Hove	E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 216.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 5 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3116
Local Reg. No. 1008
Reg. Dist. No. 440

Dr. Harold Holsinger RECEIVED
BIRTH NO.

JUL 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Benedicts Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman 240
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Edward
b. (Middle): Lea 099
c. (Last): Owsley

4. DATE OF DEATH: July 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 15, 1887

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer 25

10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

11. BIRTHPLACE (State or foreign country): Corinne, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Lea Owsley
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Mary Louisa Durfee
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-10-3885A

17. INFORMANT'S OWN SIGNATURE: X. Mirle E. Owsley
ADDRESS: Hagerman, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5020

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerosis - generalized — 10 yrs

DUE TO (c): Pulmonary Emphysema — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic Bronchitis — 10 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Old age

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 1 *1967, to* death, *19____, that I last saw the deceased alive on* 7-9, *1967, and that death occurred at* 8 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 240 Harold G. Holsinger MD

23b. ADDRESS: Wendell Idaho

23c. DATE SIGNED: 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-13-67

24c. NAME OF CEMETERY OR CREMATORY: Hagerman Cemetery

24d. LOCATION (City, town, or county) (State): Hagerman, Idaho

DATE REC'D BY LOCAL REG.: July 18, 1967

REGISTRAR'S SIGNATURE: Loretta M. Reber

25. EMBALMER: Calvin L. Meyer

LICENSE NO.: E-424

FIRM NAME: Thompson Chapel Gooding Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

SEP 21 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3117
Local Reg. No. 1006
Reg. Dist. No. 440

Certificate of Death

RECEIVED
JUL 19 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 270
a. COUNTY Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 270 Jerome
d. STREET ADDRESS (If rural, give location) 413 East Ave. "B"

3. NAME OF DECEASED (Type or Print) a. (First) JOHNNY b. (Middle) 099 JAMES c. (Last) WILLIAMSON

4. DATE OF DEATH (Month) (Day) (Year) July 10, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 26, 1910
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Pendleton, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Williamson — BIRTHPLACE Ky.
14. MOTHER'S MAIDEN NAME Ida Murphy — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 24 6101
17. INFORMANT'S OWN SIGNATURE Dana Dalles — ADDRESS Jerome, Idaho

18. CAUSE OF DEATH 9031
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary thrombosis — 2 wks.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chronic mercury poisoning — 10 yrs.
Trauma Fall on chest — 2 wks.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Fall on chest
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm 02
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Wells, 29 555 Nevada

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) June 13, 1679 a.m.
21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? Fall

22. I hereby certify that I attended the deceased from 8/10, 1962, to July 10, 1967, that I last saw the deceased alive on July 9, 1967, and that death occurred at 5:40a m., from the causes and on the date stated above.

23a. SIGNATURE James E. Noat 476 (Degree or title) MD
23b. ADDRESS Jerome Ida
23c. DATE SIGNED 7/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Filer IOOF Cemetery
24d. LOCATION (City, town, or county) (State) Filer, Twin Falls, Idaho

DATE REC'D BY LOCAL REG. July 17, 1967
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3118
Local Reg. No. 1007
Reg. Dist. No. 440

BIRTH NO.

RECEIVED JUL 19 1967 Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (If in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 270
d. STREET ADDRESS (If rural, give location): 408 East Ave E.

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Washington 099
c. (Last): Frazier

4. DATE OF DEATH (Month) (Day) (Year): July 16, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 19, 1891
9. AGE (In years last birthday): 75 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Cleveland, Arkansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Frazier — BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Louisa Williams — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 429-24-2678
17. INFORMANT'S OWN SIGNATURE: X Julia Frazier — ADDRESS: Jerome, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

465X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bleeding Esophageal Varices — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Pulmonary embolus — 17 days.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Cerebral Thrombosis — 24 dos.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-22, 1967, *to* 7-16, 1967, *that I last saw the deceased alive on* 7-15, 1967, *and that death occurred at* 12:35 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Reuben C. Matson 336 MD
23b. ADDRESS: Jerome Idaho
23c. DATE SIGNED: 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Jerome, Idaho

DATE REC'D BY LOCAL REG.: July 17, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: Ronald J. Hamilton
LICENSE NO.: E-470

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 25 1962

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3119
Local Reg. No. 1009
Reg. Dist. No. 440

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
STATE OF IDAHO
JUL 27 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 270
d. STREET ADDRESS (If rural, give location): 421 East Ave. "E"

3. NAME OF DECEASED (Type or Print)
a. (First): ANNA
b. (Middle): JANE 099
c. (Last): ROBERTSON

4. DATE OF DEATH (Month) (Day) (Year): July 22, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 12, 1879

9. AGE (In years last birthday): 88
If UNDER 1 YEAR: Months / Days
If UNDER 1 DAY: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Middle Fork, Nova Scotia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Kenneth MacRae
BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: ---- McDonald
BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 24 3733

17. INFORMANT'S OWN SIGNATURE: X Marvin Robertson
ADDRESS: Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinoma of Stomach
INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Hypertrophic osteoarthritis
12 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3/31, 19 53, *to* July 22, 19 67, *that I last saw the deceased alive on* July 15, 19 67, *and that death occurred at* 6:05a m., *from the causes and on the date stated above.*

23a. SIGNATURE: James E. Noad 476 (Degree or title) MD

23b. ADDRESS: Jerome Idaho

23c. DATE SIGNED: 7/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 25, 1967

24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery

24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: July 25, 1967

REGISTRAR'S SIGNATURE: Lorena M. Asher

25. EMBALMER: W. L. Hove

LICENSE NO.: E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3120
Local Reg. No. 1010
Reg. Dist. No. 440

BIRTH NO.

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 270 Jerome
b. CITY OR TOWN Jerome
LENGTH OF STAY (in this place) 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Benedict's Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN Buhl
420
d. STREET ADDRESS (If rural, give location) 400 N. Broadway

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) WILFRED
c. (Last) CHAPMAN

4. DATE OF DEATH (Month) (Day) (Year) July 29, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH March 26, 1885
9. AGE (In years last birthday) 82
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Station Agent
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Dresden, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin J. Chapman
BIRTHPLACE No Record
14. MOTHER'S MAIDEN NAME Sarah Ann Close
BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs Mary C Chapman
ADDRESS 400 N. Broadway Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1909

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Melanoma of skin with metastases — INTERVAL BETWEEN ONSET AND DEATH 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/27, 1967, to 7/29/67, 19___, that I last saw the deceased alive on 7/28/67, 19___, and that death occurred at 1:40 a m., from the causes and on the date stated above.

23a. SIGNATURE 477 W. Carlyle Burd (Degree or title) MD
23b. ADDRESS Jerome Idaho
23c. DATE SIGNED 8/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/1/67
24c. NAME OF CEMETERY OR CREMATORY Buhl
24d. LOCATION (City, town, or county) Buhl, (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 2, 1967
REGISTRAR'S SIGNATURE Louella M. Dekerer
25. EMBALMER Robert H. Dickard
LICENSE NO. E-312
FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information. AUG 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED — STATE OF IDAHO — Bureau of Vital Statistics — JUL 18 1967

State File No. 3121
Local Reg. No. 125
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 280 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give): Rockford Bay
c. LENGTH OF: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane 555
d. STREET ADDRESS (If rural, give location): W. 1023 Frederick

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Arthur	Wilfred	Johnson	July 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married 3	March 21, 1910	57		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Quality Control 26	Western Pine Div., Boise Cascade	Rose Lake, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Supv. Alfred Johnson		Caroline Anderson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		533-01-9745	Wife x Mrs Dana Johnson	W. 1023 Frederick

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
	Rockford Bay	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Outboard, attack came on suddenly

22. *I hereby certify that I attended the deceased from* Did Not, 19___, to ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Ward, M.D. Coroner 572 4	Coeur d'alene Idaho	7-7-'67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/6/67	Spokane Memorial Gardens	Spokane Co., Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 10 1967	Lorraine K. Brewer	Ken M. Pruitt	EL 490

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Mazen & Jaeger Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Wood

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3122
Local Reg. No. 121
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Kootenai — 28/JUL 18 1967 — 3-01 — Bureau of Vital Statistics
b. CITY OR TOWN: Coeur d' Alene — LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13 — b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene, — 281
d. STREET ADDRESS (If rural, give location): Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print): a. (First) Fred — b. (Middle) #101 — c. (Last) Engstrom
4. DATE OF DEATH: (Month) July (Day) 6 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: 2/6/1887
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred Engstrom — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Augusta Jacobson — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.I. 3
16. SOCIAL SECURITY NO.: 518-03-6085
17. INFORMANT'S OWN SIGNATURE: Elvera Engstorm — ADDRESS: Coeur d' Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-5, 1967, *to* 7-6, 1967, *that I last saw the deceased alive on* 7-6, 1967, *and that death occurred at* 10 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Wood M.D. — 23b. ADDRESS: Coeur d'alene Idaho — 23c. DATE SIGNED: 7-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 7-10-1967 — 24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery — 24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: July 10, 1967 — REGISTRAR'S SIGNATURE: Lorraine K. Brush — 25. EMBALMER: Fred H. Noland — LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

OCT 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 19 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3123
Local Reg. No. 126
Reg. Dist. No. 120

RECEIVED
JUL 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 280 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
c. LENGTH OF STAY IN THIS PLACE 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 702 E. 10th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Oregon 38
b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Oakland
d. STREET ADDRESS (If rural, give location) P.O. Box

3. NAME OF DECEASED (Type or Print) a. (First) Audrey b. (Middle) Mae c. (Last) Kincaid

4. DATE OF DEATH (Month) July (Day) 6, (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 7-15-1901

9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own HOme

11. BIRTHPLACE (State or foreign country) Black Lake, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Paul Rosco BIRTHPLACE Minnesota

14. MOTHER'S MAIDEN NAME Jane Ramey BIRTHPLACE Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-20-3979

17. INFORMANT'S OWN SIGNATURE James L. Cushman ADDRESS Kellogg, Ida.

7954

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Natural Causes, Unknown Etiology

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 1 Hour

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 7:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE C E Thompson (Degree or title) 530 MD

23b. ADDRESS 318 Eller Bldg. Coeur d'Alene, Idaho

23c. DATE SIGNED 7-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-10-1967

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. July 12, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Bill Cuff

LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3124
Local Reg. No. 123
Reg. Dist. No. 120

RECEIVED 28/JUL 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13 b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location) 719 N. 13th St.

3. NAME OF DECEASED (Type or Print) a. (First) Ethel b. (Middle) A. 101 c. (Last) Holt

4. DATE OF DEATH (Month) (Day) (Year) July 7, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 8-31-1886
9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME August Johnson BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Augusta Carlson BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None 0
16. SOCIAL SECURITY NO. 519-42-5517
17. INFORMANT'S OWN SIGNATURE X John Grant Holt ADDRESS Hayden Lake, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4437

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular decident — INTERVAL BETWEEN ONSET AND DEATH 7/6/67

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac decompensation — 1 year
DUE TO (c) Hypertensive arteriosclerotic valvular heart disease — 20 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/6/, 1967, *to* 7/7, 1967, *that I last saw the deceased alive on* 7/7, 1967, *and that death occurred at* 5:40 p m., *from the causes and on the date stated above.*

23a. SIGNATURE H. Don Moseley, M.D (Degree or title) 395
H. Don Moseley, M.D
23b. ADDRESS 421 Coeur d'Alene Ave., Cd'A
23c. DATE SIGNED 7/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-10-1967
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Ida.

DATE REC'D BY LOCAL REG. July 12, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brewer
25. EMBALMER Bill Wolff
LICENSE NO. E-439
FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3125
Local Reg. No. 127
Reg. Dist. No. 120

RECEIVED
JUL 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 281 3-21
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 21 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls 280
d. STREET ADDRESS (If rural, give location) Rt. #2

3. NAME OF DECEASED (Type or Print)
a. (First) Stephen
b. (Middle) Sy
c. (Last) Beldon
AKA: Stephen 101 Sybeldon

4. DATE OF DEATH (Month) (Day) (Year) July 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH 12-12-1878
9. AGE (In years last birthday) 88 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Keeper 25
10b. KIND OF BUSINESS OR INDUSTRY Naval Supply
11. BIRTHPLACE (State or foreign country) Stevens Point, Wisc.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Sybeldon BIRTHPLACE Poland
14. MOTHER'S MAIDEN NAME Frances (Unknown) BIRTHPLACE Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None 0
16. SOCIAL SECURITY NO. 518-12-3885
17. INFORMANT'S OWN SIGNATURE (Bd) Clara Sybeldon, Eau Claire, Wisc. ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive heart failure
DUE TO (c) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic bronchitis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1955, to _____, 1967, that I last saw the deceased alive on July 6, 1967 and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 192 (Degree or title) MD
23b. ADDRESS 2004 N 5th Cdeft
23c. DATE SIGNED 9 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-11-67
24c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Ida.

DATE REC'D BY LOCAL REG. July 12, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Duff
LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d' Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3126
Local Reg. No. 131
Reg. Dist. No. 120

Certificate of Death

RECEIVED
JUL 20 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 306
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. STAY (in this place): 5½ days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pine Wood Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene 281
d. STREET ADDRESS (If rural, give location): Coeur d'Alene, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): Hilja
b. (Middle): Tynne 261
c. (Last): Heikkila

4. DATE OF DEATH (Month) (Day) (Year): July 8, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow 2
8. DATE OF BIRTH: Aug. 27, 1891
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Tacoma, Wash.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Abraham Lehto — BIRTHPLACE: Finland
14. MOTHER'S MAIDEN NAME: Edla Jarrvi — BIRTHPLACE: Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None 331X
16. SOCIAL SECURITY NO.: 539-50-7330
17. INFORMANT'S OWN SIGNATURE: Tefnara Heikkila — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral vascular accident	25 days
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral arteriosclerosis	years
DUE TO (c)	Generalized arteriosclerosis	years
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes mellitus	16 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1967, *to* July 8, 1967, *that I last saw the deceased alive on* July 7, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 568 W. Wray Wilson MD 1
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED: 7/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 12, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rose Lake
24d. LOCATION (City, town, or county) (State): Rose Lake, Idaho

DATE REC'D BY LOCAL REG.: July 15, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Neuff — LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3127
Local Reg. No. 130
Reg. Dist. No. 120

RECEIVED
JUL 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 00C
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): 309 Military Drive

3. NAME OF DECEASED (Type or Print): a. (First) Frank; b. (Middle) E. 101; c. (Last) Reynolds

4. DATE OF DEATH: (Month) JUly (Day) 11, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 8-5-1895

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Saleman 24

10b. KIND OF BUSINESS OR INDUSTRY: Car Dealer

11. BIRTHPLACE (State or foreign country): Detroit, Mich.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ed Reynolds
BIRTHPLACE: Mich.

14. MOTHER'S MAIDEN NAME: Not obtainable
BIRTHPLACE: Not obtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ----
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 518-26-5456

17. INFORMANT'S OWN SIGNATURE: Coeur d'Alene ADDRESS Wilbur M. Reynolds Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1965, *to* 7/11, 1967, *that I last saw the deceased alive on* 7/11, 1967, *and that death occurred at* 10:20 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 174 M.D.

23b. ADDRESS: Coeur d'Alene Ida

23c. DATE SIGNED: 7/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-14-1967

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.: July 17, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Bill Neff
LICENSE NO.: E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Frank E. Reynolds

now lying buried in Forest Cemetery Cemetery, in the City or Town of Coeur d'Alene

County of Kootenai State of Idaho, who died on the 11th day of July, 1967, Aged 72 years ____ months

____ days, the cause of death being Acute Myocardial Infarction and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Dr. E. R. W. Fox attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Railway
private or railway conveyance

to Morenci Cemetery in the City or Town of Morenci County of --

State of Michigan to take effect upon the approval by the local board of health of the City, Town, or County of

Kootenai it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 30th day of August, A.D. 1967.

Permit issued to:
English Chapel
Coeur d'Alene, Idaho

W. W. Benson
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of ____ State of Idaho, this ____ day of ____, 19__.

Health Officer

FORM BH 56-019

TITLE 39, CHAPTER 2, VOL. 7 OF THE IDAHO CODE

JAN 10 1968

"Sec. 39-211. No body shall be disinterred within the State of Idaho except upon a permit granted by the State Board of Health. The forms of disinterment permits shall be prepared by the State Board of Health. Disinterment and removal must be done under the personal supervision of a licensed embalmer, and must be done at an hour when there is the least possible exposure. Only such persons as are actually necessary shall be present. The coffin shall not be opened either at place of disinterment or place of destination, except special permit be issued by the State Board of Health. And in case of disinterment of bodies dead by reason of contagious and infectious diseases, as shown by the certificate of death given by the attending physician, the sexton and all other persons engaged in such removal or being present shall immediately thereafter change their clothing and properly disinfect their hands, head and face, provided, that such disinterment may also be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every permit: provided, also, that in case of any contagious and infectious disease where remains are to be shipped to points in other states, permission must first be obtained from the Secretary of State Board of Health of such State. The State Board of Health may also issue a special disinterment permit for legal purposes. This permit for legal purposes shall be granted only upon application of a prosecuting attorney or the Attorney General of this State, stating therein such facts which make it evident to the State Board of Health that the ends of justice require that disinterment be permitted. Such special disinterment for legal purposes shall be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every such special disinterment permit for legal purposes."

State File No. 3128
Local Reg. No. 136
Reg. Dist. No. 120

Certificate of Death

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 280 Kootenai 404
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place) Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cave Bay Resort 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane 555
d. STREET ADDRESS (If rural, give location) E. 317 Courtland Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) Fred
b. (Middle) Charles
c. (Last) Meyers

4. DATE OF DEATH (Month) (Day) (Year) July 11, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 21, 1887
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) (Ret) Meat Cutter 21
10b. KIND OF BUSINESS OR INDUSTRY Meekers Market or Rockwood Market
11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles J. Meyers
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Ida Peterson
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 533-01-0907
17. INFORMANT'S OWN SIGNATURE Gladys M. Meyers
ADDRESS E. 317 Courtland Wife

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Collapsed while fishing

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 583 (Degree or title) Coroner 4
23b. ADDRESS Coeur d'Alene Idaho
23c. DATE SIGNED 7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/15/67
24c. NAME OF CEMETERY OR CREMATORY Fairmount Memorial Park
24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. July 19, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Milo W. Slind
LICENSE NO. 283

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hazen & Jaeger Funeral Home-Spokane

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 5 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3129
Local Reg. No. 129
Reg. Dist. No. 126

BIRTH NO.

RECEIVED
JUL 20 1967
Bureau of Vital Statistics

281

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY in this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): 1039 N. 3rd

3. NAME OF DECEASED (Type or Print): a. (First) George b. (Middle) 101 c. (Last) Christman

4. DATE OF DEATH: (Month) July (Day) 12, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 9-10-1896

9. AGE (In years last birthday): 70 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Not Available
BIRTHPLACE: ------

14. MOTHER'S MAIDEN NAME: Not Available
BIRTHPLACE: -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 503-32-7492

17. INFORMANT'S OWN SIGNATURE: Mrs. Gence Larson (Co)
ADDRESS: Coeur d'Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — 2 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia — 3 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July 3, 1967, *to* July 12, 1967, *that I last saw the deceased alive on* July 11, 1967, *and that death occurred at* 1:10 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 530 (Degree or title): MD
23b. ADDRESS: 318 Elder Bldg. Coeur d'Alene, Idaho
23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-15-1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.: July 17, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brueck
25. EMBALMER: [signature]
LICENSE NO.: E-439
FIRM NAME: English Chapel-Coeur d' Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 16 1968

FEB 29 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3130
Local Reg. No. 132
Reg. Dist. No. 120

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF (If outside place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): Route #3

3. NAME OF DECEASED (Type or Print)
a. (First): Sidney
b. (Middle): Vernon 101
c. (Last): Streator

4. DATE OF DEATH (Month) (Day) (Year): July 12, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 11-21-1872
9. AGE (In years last birthday): 94 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Commercial Artist
10b. KIND OF BUSINESS OR INDUSTRY: American Lumb.
11. BIRTHPLACE (State or foreign country): Garrettsville, Ohio
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George J. Streator 21 — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Francelia Parker — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 319-05-4312-A
17. INFORMANT'S OWN SIGNATURE: Francelia D Crawford — ADDRESS: Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident 331X — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Congestive heart failure

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1953, to _____, 1967, that I last saw the deceased alive on July 10, 1967, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald M Gruenecht, MD 192
23b. ADDRESS: 302 W 5th
23c. DATE SIGNED: 14 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 7-15-1967
24c. NAME OF CEMETERY OR CREMATORY: Moon Crematory
24d. LOCATION (City, town, or county) (State): Sandpoint, Idaho

DATE REC'D BY LOCAL REG.: July 15, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Duff
LICENSE NO.: E-439

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3131
Local Reg. No. 135
Reg. Dist. No. 120

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): 10 Yrs 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene Idaho 281
d. STREET ADDRESS (If rural, give location): 1902 N 4th St

3. NAME OF DECEASED (Type or Print)
a. (First): Georgia
b. (Middle): Neal
c. (Last): Larabie

4. DATE OF DEATH (Month) (Day) (Year): July 13 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: March 5, 1913
9. AGE (In years last birthday): 54 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Monatana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Neal — BIRTHPLACE: Unkown
14. MOTHER'S MAIDEN NAME: Unkown — BIRTHPLACE: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None — (If yes, give war or dates of service): None 0
16. SOCIAL SECURITY NO.: 538 12 5472
17. INFORMANT'S OWN SIGNATURE: Mr. Lloyd Slaght — ADDRESS: Coeur d' Alene, Idaho

18. CAUSE OF DEATH 172X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Endometrial Carcinoma — 18 mo.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 3.16.67
19b. MAJOR FINDINGS OF OPERATION: Endometrial Carcinoma
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2.10, 1967, *to* 7.13, 1967, *that I last saw the deceased alive on* 7.13, 1967, *and that death occurred at* 6:55 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Albert H. Ryan Jr. MD 313 (Degree or title)
23b. ADDRESS: 411 Coeur d'Alene Ave.
23c. DATE SIGNED: 7.17.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 14, 67
24c. NAME OF CEMETERY OR CREMATORY: White Funeral Home
24d. LOCATION (City, town, or county) (State): Butte, Montana

DATE REC'D BY LOCAL REG.: July 19 1967
REGISTRAR'S SIGNATURE: Lorraine K Brush
25. EMBALMER: Gilbert D. Yates — LICENSE NO.: E-365

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 16 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 13 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3132
Local Reg. No. 13
Reg. Dist. No. 120

RECEIVED
JUL 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): 415 E. Garden

3. NAME OF DECEASED (Type or Print)
a. (First): Verna
b. (Middle): T. 101
c. (Last): Blackmer

4. DATE OF DEATH: (Month) July (Day) 14, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 29, 1898
9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own HOme
11. BIRTHPLACE (State or foreign country): Coeur d' Alene, Ida.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: W. J. Totten
BIRTHPLACE: Not Available
14. MOTHER'S MAIDEN NAME: Alice ?
BIRTHPLACE: Not Available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None 0
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Leon E Blackmer ADDRESS: 415 E. Garden Coeur d'alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: 128 (Degree or title)
23b. ADDRESS: Coeur d'alene, Idaho
23c. DATE SIGNED: 7-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 7-17-1967
24c. NAME OF CEMETERY OR CREMATORY: Moon Crematory
24d. LOCATION (City, town, or county): Sandpoint, (State): Idaho

DATE REC'D BY LOCAL REG.: July 19, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Neff
LICENSE NO.: E-439
FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Wilson

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3133
Local Reg. No. 439
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 JUL 27 1967
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION Coeur d' Alene Homes 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location) Northwest Blvd.

3. NAME OF DECEASED (Type or Print) a. (First) Ida b. (Middle) c. (Last) Tomlinson

4. DATE OF DEATH (Month) (Day) (Year) July 15, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH 10-29-1894

9. AGE (In years last birthday) 72 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Eau Claire, Wisc.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Carl Petztrick

BIRTHPLACE

14. MOTHER'S MAIDEN NAME Mary

BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) NOne 0

16. SOCIAL SECURITY NO. 544-03-6669

17. INFORMANT'S OWN SIGNATURE Cda Homes Records ADDRESS Ft. Cda.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen debility — 2 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Blindness — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1965, *to* July 15, 1967, *that I last saw the deceased alive on* June 1, 1967 *and that death occurred at* 6:10 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 568 W. Wray Wilson MD

23b. ADDRESS Coeur d'alene, Ida

23c. DATE SIGNED 7/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-20-1967

24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery

24d. LOCATION (City, town, or county) Moscow, (State) Idaho

DATE REC'D BY LOCAL REG. July 20, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brueck

25. EMBALMER Bill Ruff

LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3134
Local Reg. No. 142
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 5 yrs. 705
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinewood Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): 2514 N. 7th. St.

3. NAME OF DECEASED (Type or Print)
a. (First): Emma
b. (Middle): 261
c. (Last): Morlin

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 5-9-1890

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Wausau, Wis.

12. CITIZEN OF WHAT COUNTRY?: U.SA

13. FATHER'S NAME: James Sexton
BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Clara Stevens
BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 541-07-4458B

17. INFORMANT'S OWN SIGNATURE: Axel Moatin
ADDRESS: Coeur d' Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Pneumonia 4288
INTERVAL BETWEEN ONSET AND DEATH: one week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Severe A SHD
INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug 12, 1967, *to* July 17, 1967, *that I last saw the deceased alive on* July 15, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. H. Johnston 658 MD
23b. ADDRESS: Hayden Lake Idaho
23c. DATE SIGNED: 7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 20, 67
24c. NAME OF CEMETERY OR CREMATORY: Riverview Abby Mausoleum
24d. LOCATION (City, town, or county) (State): Portland, Oregon

DATE REC'D BY LOCAL REG.: July 25, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Breuch

25. EMBALMER: Fred H. Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3135
Local Reg. No. 138
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 581 309
b. CITY OR TOWN Coeur d'Alene
LENGTH OF STAY (In this place) 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hayden Lake 280
d. STREET ADDRESS (If rural, give location) Box 54

3. NAME OF DECEASED (Type or Print) a. (First) Harold b. (Middle) Franklin 101 c. (Last) Clinton

4. DATE OF DEATH (Month) July (Day) 19, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 11-22-1896

9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Harney, Washington

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Clinton BIRTHPLACE Indiana

14. MOTHER'S MAIDEN NAME Mary Hall BIRTHPLACE Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I 3

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE ADDRESS Mrs. Cleo Clinton, Hayden Lake, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 163X
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1967, *to* July 19, 1967, *that I last saw the deceased alive on* July 19, 1967, *and that death occurred at* 6:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE R. H. [illegible] 658 (Degree or title) MD
23b. ADDRESS Hayden Lake Idaho
23c. DATE SIGNED 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE July 20, 1967
24c. NAME OF CEMETERY OR CREMATORY Hazen & Jaeger Funeral Hm.
24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. July 26, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred H. Noland
LICENSE NO. E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 27 1967 Bureau of Vital Statistics

State File No. 3136
Local Reg. No. 133
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): 1015 St. Maries Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Rosa b. (Middle) Irene 101 c. (Last) Anderson

4. DATE OF DEATH: (Month) July (Day) 20, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 11-3-1880

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): W. Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John McDaniels
BIRTHPLACE: W. Virginia

14. MOTHER'S MAIDEN NAME: Unobtainable
BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none 0

16. SOCIAL SECURITY NO.: 518-05-4041-D

17. INFORMANT'S OWN SIGNATURE: Claude Anderson ADDRESS Coeur d'Alene Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Kimmelstiel-Wilson Disease — unknown

DUE TO (c) Diabetes mellitus — 12+ years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 13, 1967, *to* July 20, 1967, *that I last saw the deceased alive on* July 19, 1967, *and that death occurred at* 2:45A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 568 William Wilson MD

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-21-1967

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: July 21, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brewer

25. EMBALMER: Bill Duff

LICENSE NO.: E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3137
Local Reg. No. 141
Reg. Dist. No. 120

BIRTH NO.

281

AUG - 3 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls 280
d. STREET ADDRESS (If rural, give location): 1117 Henry St.

3. NAME OF DECEASED (Type or Print): a. (First) Leonard — b. (Middle) D. 101 — c. (Last) Monette

4. DATE OF DEATH: (Month) July (Day) 21, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	4/28/1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Retired	Milback, South Dakota	U.S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George B. Monette	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	553-03-1360	Mrs. Anis Monette	Post Falls, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19 50, *to* 7-21, 19 67, *that I last saw the deceased alive on* 7-21, 19 67, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. Coroner 532	Coeur d'Alene Idaho	7-26-'67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/25/1967	Fairmont Memorial Park	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 26, 1967	Lorraine K. Brush	Fred H. Noland	E-493

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Yates Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3138
Local Reg. No. 139
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rt. # 1
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 mls. N. & 2½ Mls. E of Hayden Lk. Rt. # 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hayden Lake 280
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Clarence- b. (Middle) J. 000 c. (Last) Gantner

4. DATE OF DEATH: (Month) July (Day) 22, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Aug. 7, 1893

9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown 00

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Evansville, Indiana

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ~~No~~ W.W.I. (If yes, give war or dates of service): Army 3

16. SOCIAL SECURITY NO.: 539-05-9419A

17. INFORMANT'S OWN SIGNATURE — ADDRESS

18. CAUSE OF DEATH 7754

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cause Unknown – Disease. — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY occur? found dead near pipe wrench in hand

22. *I hereby certify that I attended the deceased from* Did not *, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 583 William T. Wood, M.D. (Degree or title) Coroner

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 7-26-'67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-28-1967

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: July 26, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred H. Noland — LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3139
Local Reg. No. 140
Reg. Dist. No. 120

BIRTH NO.

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

281 306

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls 280
d. STREET ADDRESS (If rural, give location): 509 6th. St.

3. NAME OF DECEASED (Type or Print): a. (First) Carl b. (Middle) Albert 101 c. (Last) Hallstrom

4. DATE OF DEATH: (Month) July (Day) 27, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 4-18-1894

9. AGE (In years last birthday): 73 | IF UNDER 1 YEAR Months: | Days: | IF UNDER 24 HRS. Hours: | Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Worker 29

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Sweden

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Johan Albert — BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Anna Stride — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 533-01-6667

17. INFORMANT'S OWN SIGNATURE: Agnes Oslund — ADDRESS: Coeur d' Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 4 years
DUE TO (c) Hypertension — 4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. diabetes mellitus — 6 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-3-[illegible], to 7-28-[illegible], that I last saw deceased alive on 7-[illegible], and that death occurred at 11:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE: [illegible] 026 (Degree or title) M.D.
23b. ADDRESS: Coeur d'Alene
23c. DATE SIGNED: 7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-31-67
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: July 31, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Fred H. Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3140
Local Reg. No. 147
Reg. Dist. No. 120

BIRTH NO.

AUG 11 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): 608 S. 11th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Daniel
b. (Middle): 101
c. (Last): Masten

4. DATE OF DEATH (Month) (Day) (Year): July 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 9-3-1880
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ship Builder 10
10b. KIND OF BUSINESS OR INDUSTRY: Ship Yards
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Morris D. Masten — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Luella Kane — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No 0
16. SOCIAL SECURITY NO.: 072-05-5386
17. INFORMANT'S OWN SIGNATURE: Wesley Masten (SD) — ADDRESS: Coeur d'Alene, Ida

493X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Carcinoma prostate — 4 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-28, 1967, *to* 7-28, 1967, *that I last saw the deceased alive on* 7-28, 1967, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 025 Frank Darlay MD
23b. ADDRESS: Coeur d'Alene Ida.
23c. DATE SIGNED: 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-1-1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.: Aug. 2, 1967
REGISTRAR'S SIGNATURE: Lorraine K Brush
25. EMBALMER: N. F. Riplinger Jr.
LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel=Coeur d' Alene

AUG 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 10 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. AUG 28 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3141
Local Reg. No. 145
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 281
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital
d. STREET ADDRESS (If rural, give location) 213 Garden

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai

3. NAME OF DECEASED (Type or Print)
a. (First) Magne
b. (Middle) C. 101
c. (Last) Larson

4. DATE OF DEATH (Month) July (Day) 29, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH 2-3-1911
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber 17
10b. KIND OF BUSINESS OR INDUSTRY Sawmill
11. BIRTHPLACE (State or foreign country) Coeur d' Alene, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harry Larson — BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Petra Gragaard — BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W.W. II 4 3221
16. SOCIAL SECURITY NO. 535-03-5991
17. INFORMANT'S OWN SIGNATURE Louis Larson — ADDRESS Coeur d'Alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 7-24-67

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic alcoholism — 20 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1940, to July 29, 1967, that I last saw the deceased alive on July 29, 1967, and that death occurred at 2:05 p.m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 188 (Degree or title) MD
23b. ADDRESS Coeur d'alene, Ida.
23c. DATE SIGNED 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-1-1967
24c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Pk.
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Ida.

DATE REC'D BY LOCAL REG. Aug. 2, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Ripling er Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

DUTIES: AUG 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3142
Local Reg. No. 143
Reg. Dist. No. 120

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 280 AUG 1 1 1967 117
b. CITY OR TOWN: Post Falls
c. LENGTH OF STAY (In this place): 17 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 208 12th. St. (Home) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls 280
d. STREET ADDRESS (If rural, give location): 208 12th. St.

3. NAME OF DECEASED (Type or Print): a. (First) Harry b. (Middle) R. c. (Last) Bright

4. DATE OF DEATH: (Month) July (Day) 29, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 10-27-1877

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Road Construction 11

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mazeppa, Minn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Tha ddius Bright
BIRTHPLACE: Minn.

14. MOTHER'S MAIDEN NAME: Ruth Spicer
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 475-09-4198 A

17. INFORMANT'S OWN SIGNATURE: Flora May - Post Falls, Idaho
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4291 Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Did not, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: William T. Wood 583 (Degree or title) M.D. Coroner 4

23b. ADDRESS: Coeur d'alene Idaho

23c. DATE SIGNED: 8-2-'67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 2, 1967

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cmeetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idahi

DATE REC'D BY LOCAL REG.: Aug 2, 1967

REGISTRAR'S SIGNATURE: Lorraine K Brush

25. EMBALMER: Fred H. Nodnand

LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3143
Local Reg. No. 146
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY KOOTENAI 281 AUG 1 1 1967 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) COEUR D' ALENE
c. LENGTH OF STAY (In this place) 1-hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) KOOTENAI MEMORIAL HOSPITAL

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY KOOTENAI
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) COEUR D' ALENE 281
d. STREET ADDRESS (If rural, give location) 613-INDIANA AVENUE

3. NAME OF DECEASED (Type or Print)
a. (First) EDWARD
b. (Middle) J. 101
c. (Last) MARIER

4. DATE OF DEATH (Month) (Day) (Year) JULY 30, 1967

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2
8. DATE OF BIRTH APRIL 26, 1902
9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED 29
10b. KIND OF BUSINESS OR INDUSTRY KAISER ROLLING MILL
11. BIRTHPLACE (State or foreign country) CANADA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Marier — BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Bernier — BIRTHPLACE Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service) NONE 0
16. SOCIAL SECURITY NO. 519-20-0154
17. INFORMANT'S OWN SIGNATURE Leo L. Marier — ADDRESS 615-Cd'a Av. Coeur d' Alene, Ida.

4281

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-21-65 *19*___, *to* 12-2-66, *19*___, *that I last saw the deceased alive on* _____, *19*___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE D. A. Daugherty M.D. 128 (Degree or title)
23b. ADDRESS D. A. DAUGHARTY M. 816 SHERMAN AVE. COEUR D'ALENE, IDAHO
23c. DATE SIGNED AUG 1 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE Aug. 2-1967
24c. NAME OF CEMETERY OR CREMATORY St. Thomas Cem.
24d. LOCATION (City, town, or county) Coeur d' Alene, Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 7, 1967
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER N. F. Riplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ENGLISH CHAPEL

DUTIES:

AUG 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3144
Local Reg. No. 200
Reg. Dist. No.

RECEIVED JUL 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN: Moscow
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location): Rural Rt. I

3. NAME OF DECEASED (Type or Print): a. (First) Andrew b. (Middle) 329 c. (Last) Kertez

4. DATE OF DEATH: (Month) July (Day) 15 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 1874

9. AGE (In years last birthday): 93 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Gardening

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unavailable — BIRTHPLACE: Unavailable

14. MOTHER'S MAIDEN NAME: Unavailable — BIRTHPLACE: Unavailable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): ——— (If yes, give war or dates of service): ———

16. SOCIAL SECURITY NO.: 519-60-8383

17. INFORMANT'S OWN SIGNATURE: X Raymond A. Johnson — ADDRESS: Glen Ca'n,

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4341

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): None

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 21, 1967, *to* July 2, 1967, *that I last saw the deceased alive on* June 29, 1967, *and that death occurred at* 1:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Edward L. Boas 788 (Degree or title): M.D.

23b. ADDRESS: Professional Bldg. Moscow Idaho

23c. DATE SIGNED: July 7, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7-6-1967

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: 7-14-67

REGISTRAR'S SIGNATURE: Cheryl Ann Williams

25. EMBALMER: Bill Neff

LICENSE NO.: E-439

FIRM NAME: English Chapel - Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3145
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED JUL 18 1967 VITAL STATISTICS Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 29 Latah 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Potlatch 290
d. STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Victoria	Martha	Dygert	July	3	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	widowed 2	June 2, 1903	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		Fernie, B.C., Canada	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Batter	Canada	Magdeline Rockfitz	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-54-1308	X Jarene Pope	Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4208 Acute Pulmonary Edema

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Atherosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Occlusive Peripheral Arteries

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-2-67	Occlusion Rt. Iliac & Femoral Arteries	YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-1, 1967, *to* 7-3, 1967 *that I last saw the deceased alive on* 7-3, 1967 *and that death occurred at* 3 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Darryl C. Valden MD 541	Moscow Idaho	7-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 6, 1967	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-14-67	Cheryl Ann Williams	Donald Ward	E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 29 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3146
Local Reg. No. 200
Reg. Dist. No.

RECEIVED
JUL 24 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 10 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 2 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow 291
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print)
a. (First): Theodore
b. (Middle): Martin
c. (Last): Severson

4. DATE OF DEATH (Month) (Day) (Year): July 10 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single 1
8. DATE OF BIRTH: Jan 3, 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Palouse, Wash.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel Severson — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Annie Nelson — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 2 4
16. SOCIAL SECURITY NO.: 518-18-8926
17. INFORMANT'S OWN SIGNATURE: John Severson — ADDRESS: Albion, Wn.

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*
(a) Was found dead sitting in a chair. Had been out in the heat.
INTERVAL BETWEEN ONSET AND DEATH: Short while

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Probably coronary occlusion. Treated him for coronary heart disease in 1965.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: I saw this man at the funeral parlor after he was brought in.
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 310 Loder 1
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 7-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 7-21-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 7 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3147
Local Reg. No. 200
Reg. Dist. No.

RECEIVED
JUL 24 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 — 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Potlatch 290
d. STREET ADDRESS (If rural, give location): 845 Larch St.

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle):
c. (Last): Rueppel

4. DATE OF DEATH (Month) (Day) (Year): July 10 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Sept 14, 1897
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): auto mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dysart, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Rueppel — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Martha Zinkribe — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-03-6698
17. INFORMANT'S OWN SIGNATURE: Walter B. Rueppel — ADDRESS: Deary, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MASSIVE ASPIRATION OF GASTRIC CONTENTS — INTERVAL BETWEEN ONSET AND DEATH: INSTANT

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Right Femoral herniation of small intestine w/obstruction — 3 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Diabetes Mellitus
Arteriosclerotic Heart Disease & Cardiovascular — YEARS

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-10, 1967, *to* 7-10, 1967, *that I last saw the deceased alive on* 7-10, 1967, *and that death occurred at* 10:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Norris A. Biggerstaff, M.D. .042
23b. ADDRESS: 225 Sixth St. Potlatch, Idaho
23c. DATE SIGNED: 7/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE:
24c. NAME OF CEMETERY OR CREMATORY: Mendenhall Cemetery
24d. LOCATION (City, town, or county) (State): near Potlatch Ida.

DATE REC'D BY LOCAL REG.: 7-21-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 24 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3148
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 291 Latah 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy 290
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Arthur
b. (Middle)
c. (Last) Showalter

4. DATE OF DEATH (Month) July (Day) 11 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) single

8. DATE OF BIRTH Feb 26, 1890

9. AGE (In years last birthday) 77
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (State or foreign country) Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George M. Showalter
BIRTHPLACE Virginia

14. MOTHER'S MAIDEN NAME Elizabeth Harrison
BIRTHPLACE Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW I 3

16. SOCIAL SECURITY NO. 518-36-2017

17. INFORMANT'S OWN SIGNATURE x Mrs Clarence Showalter
ADDRESS Spokane, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Complications of age — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cerebrovascular — years
DUE TO (c) " Heart disease — "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Probable Ca metastatic to liver — months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-1, 1967, *to* 7-11, 1967, *that I last saw the deceased alive on* 7-10, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Owen A Dewey 148 (Degree or title) MD
23b. ADDRESS Troy Idaho
23c. DATE SIGNED 7-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Burnt Ridge Cemetery
24d. LOCATION (City, town, or county) Troy (State) Idaho

DATE REC'D BY LOCAL REG. 7-21-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER Conrad Ward
LICENSE NO. E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

DUTIES:

AUG 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3140
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 291 JUL 24 1967 3-04
b. CITY OR TOWN: Moscow
c. LENGTH OF STAY (in this place): 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow 291
d. STREET ADDRESS (If rural, give location): 446 East 8th.

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Nataline	Marie	Tusberg	July 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Feb. 5, 1922	45				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	at home	Davenport, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Raymond Keef	Davenport, Iowa	Gladys Nolan	Davenport, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-40-8443	Arthur B. Tusberg	Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Carcinoma of sigmoid colon	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	metastatic carcinoma	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	overdose of barbiturates	

1533

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 27 Sept, 1966, *to* 15 July, 1967, *that I last saw the deceased alive on* 15 July, 1967, *and that death occurred at* 3:15 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
057	Moscow Idaho	19 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation 2	July 18, 1967	Hazen-Jaeger Funeral Home	Spokane Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-21-67	Cheryl Ann Williams	Ronald Ward	E-380

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

JUL 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 19 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3150
Local Reg. No. 200
Reg. Dist. No.

RECEIVED AUG - 1 1967 Bureau

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow 291
d. STREET ADDRESS (If rural, give location): 910½ So. Harrison

3. NAME OF DECEASED (Type or Print)
a. (First): Frank
b. (Middle):
c. (Last): Headrick

4. DATE OF DEATH (Month) (Day) (Year): July 17 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Sept 7, 1902
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): maintenance Dept. 06
10b. KIND OF BUSINESS OR INDUSTRY: U. of Idaho
11. BIRTHPLACE (State or foreign country): Linville, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Rueben Headrick — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Minnie Henshaw — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-01-8669
17. INFORMANT'S OWN SIGNATURE: X Clara M. Headrick — ADDRESS: Moscow

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 20 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Occlusion — 20 hours
DUE TO (c): Arteriosclerotic Heart Disease — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1963, *to* July 17, 1967, *that I last saw the deceased alive on* July 17, 1967, *and that death occurred at* 1:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B Adams, MD 001
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 7/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 7-28-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. [ICA 38-206 and 215.] Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3151
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 4 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) GRITMAN HOSPITAL 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls 280
d. STREET ADDRESS (If rural, give location) Ross Point

3. NAME OF DECEASED (Type or Print) a. (First) Della b. (Middle) c. (Last) Neise

4. DATE OF DEATH (Month) (Day) (Year) July 18, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH UNKNOWN

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) North Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin J. Asher BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Rachiel Mangum BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None 0

16. SOCIAL SECURITY NO. 520-20-9097

17. INFORMANT'S OWN SIGNATURE Mabel Chase ADDRESS R 2 Post Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3317

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 4 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) None

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 17, 1967, to July 18, 1967, that I last saw the deceased alive on July 17, 1967, and that death occurred at 5:50 A.m., from the causes and on the date stated above.

23a. SIGNATURE Edward L. Boas 788 (Degree or title) MD

23b. ADDRESS Professional Building, Moscow

23c. DATE SIGNED 7-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-21-1967

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho

DATE REC'D BY LOCAL REG. 7-28-67

REGISTRAR'S SIGNATURE Cheryl Ann Williams

25. EMBALMER Donald Ward

LICENSE NO. E-380

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3152
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291 AUG - 1 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Montana 27
b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Anaconda
d. STREET ADDRESS (If rural, give location) 313 W. Park

3. NAME OF DECEASED (Type or Print)
a. (First) Timothy
b. (Middle) 000 James
c. (Last) Quane

4. DATE OF DEATH (Month) July (Day) 18, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH April 16, 1947
9. AGE (In years last birthday) 20 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Smelterman 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Anaconda, Montana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William R. Quane — BIRTHPLACE Montana
14. MOTHER'S MAIDEN NAME June L. Salvail — BIRTHPLACE Florida

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Yes
17. INFORMANT'S OWN SIGNATURE David R. Sate — ADDRESS Moscow

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Cerebral Contusion + Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple Cranial + Facial Fractures — Minutes
DUE TO (c) Auto Accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) Moscow 06 Pullman Highway
21c. (CITY, TOWN, OR TOWNSHIP) 13 Moscow 291 (COUNTY) Latah (STATE) Idaho

21d. TIME OF INJURY (Month) July (Day) 18, (Year) 1967 (Hour) approx. 7 A.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto Accident

22. *I hereby certify that I attended the deceased from* DOA at, 19 Gritman, 19 Hosp. *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 1:45 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE 058 M. Brooks MD (Degree or title)
23b. ADDRESS Moscow Idaho
23c. DATE SIGNED July 24 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE July 19, 1967
24c. NAME OF CEMETERY OR CREMATORY Finnegan Funeral Home
24d. LOCATION (City, town, or county) Anaconda, (State) Montana

DATE REC'D BY LOCAL REG. 7-28-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER Donald Ward
LICENSE NO. E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 94-3153
Local Reg. No. 200
Reg. Dist. No.

RECEIVED JUL 24 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 29 Latah
b. CITY OR TOWN Moscow
Length of stay in this place: 13 months
d. FULL NAME OF HOSPITAL OR INSTITUTION Paradise Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Idaho 250
c. CITY OR TOWN Grangeville
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) Martin b. (Middle) Luther 329 c. (Last) Ayers

4. DATE OF DEATH: (Month) July (Day) 19 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 8, 1878
9. AGE (In years last birthday): 89 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate 24
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): Surrey County, N. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S SIGNATURE: J M Ayers — ADDRESS: Moscow, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcenoma Prostate — 1.5 yrs.
DUE TO (c) Pernicious Anemia — 15 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: J M Ayers MD (Degree or title) — 23b. ADDRESS: Moscow Idaho — 23c. DATE SIGNED: 19 July 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Prairie View Cemetery
24d. LOCATION (City, town, or county) (State): Grangeville Idaho

DATE REC'D BY LOCAL REG.: 7-21-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Donald Ward — LICENSE NO.: E-380
FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3154
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 291 Latah 107
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 7 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 818 S. Logan St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow 291
d. STREET ADDRESS (If rural, give location) 818 S. Logan St.

3. NAME OF DECEASED (Type or Print)
a. (First) Royal
b. (Middle) Bert
c. (Last) Lemon

4. DATE OF DEATH (Month) July (Day) 27 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Jan. 28, 1876
9. AGE (In years last birthday) 91 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Morrow County, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Lemon — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Pearl Armstrong — BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 516-40-4850A
17. INFORMANT'S OWN SIGNATURE Ferry G. Lemmon — ADDRESS Moscow, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home
21c. (CITY, TOWN, OR TOWNSHIP) Moscow (COUNTY) Latah (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Approx 3:00 P *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 3:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE 583 Co. Co. (Degree or title) W. Brooks 4 M.D.
23b. ADDRESS Moscow, Idaho
23c. DATE SIGNED Aug. 1, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE July 31, 1967
24c. NAME OF CEMETERY OR CREMATORY Dokken-Nelson Mortuary
24d. LOCATION (City, town, or county) Bozeman (State) Montana

DATE REC'D BY LOCAL REG. 8-4-67
REGISTRAR'S SIGNATURE Cheryll Ann Williams
25. EMBALMER Donald Ward
LICENSE NO. E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 13 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 39955
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 — 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow — LENGTH OF STAY (in this place): 6 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow — 291
d. STREET ADDRESS (If rural, give location): 506 East E.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ellis	Austin	Foster	July 29 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed 2	July 22, 1888	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laboren 06		Indiana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John M. Foster	Indiana	Caroline E. Bowers	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-01-8147	X Jesse E. Foster	Viola, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: none

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April 17, 1967, *to* July 29, 1967, *that I last saw the deceased alive on* July 10, 1967, *and that death occurred at* 11:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward L Boos 788 MD	Professional Bldg Moscow	8-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 31, 1967	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-14-67	Cheryl Ann Williams	Donald Ward	E-380

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3156
Local Reg. No. 670
Reg. Dist. No.

BIRTH NO.

JUL 21 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): near Indianola Ranger Station
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon 300
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lena		Bartlett	7	1	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	widowed 2	Aug. 14, 1893	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Salmon, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Isiah Bohannon	Michigan	Josephine Snyder	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Madelene McCart	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) asphyxiation by drowning

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Pick-up which whe was a passenger in left highway, rolled down embankment into Salmon River
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	Salmon River	near Indianola Ranger Station 300 Lemhi Ida.

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY Ooccur?
7	1	67	p.m.		Pick up skidded off highway into River

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 2 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Delbert C. Jones 583 Lemhi Co Coroner	Salmon, Idaho	7-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 17, 1967	Salmon	Salmon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-67	Viola E Johnson	Delbert C. Jones	E-369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 20 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3157
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon | LENGTH OF STAY (in this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steel Memorial Hospital 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon 300
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Rose	Eleanor	Fike	7	4	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	divorced 4	Mar. 24, 1911	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Salmon, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Frank Munkres	Nebraska	Leah Nichols	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Harold Fike	Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) congenital cystic lung disease
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct, 19 63 *to* 7-4, 19 67, *that I last saw the deceased alive on* 7-3, 19 67, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D. 263		Salmon Idaho	7-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	July 8, 1967	Salmon	Salmon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 9 1967	Viola E. Johnson	Delbert C. Jones	E-369

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3158
Local Reg. No. 690
Reg. Dist. No.

67-7933
BIRTH NO.

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 308
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial Hospital 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis 190
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Patty
b. (Middle): Sue
c. (Last): Savage

4. DATE OF DEATH (Month) 7 (Day) 13 (Year) 67

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married /
8. DATE OF BIRTH: July 5, 1967
9. AGE (In years last birthday): If under 1 year: Months / Days 8; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salmon, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Gerald Savage
BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Judy Thompson
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: + Gerald N. Savage
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity + 7635
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aspiration Pneumonia 7 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth *19*, *to* death *19*, *that I last saw the deceased alive on* 7-12, 1967, *and that death occurred at* 12:15 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W Blackwood M.D. 045
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Challis
24d. LOCATION (City, town, or county): Challis, (State): Idaho

DATE REC'D BY LOCAL REG.: 7-19-67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E-369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3159
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO. 300

1. PLACE OF DEATH
a. COUNTY: Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial Hospital 117

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Jess	Albert	Everson	7	14	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	O	May 4, 1896	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OO
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fond du Lac, Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles S. Everson — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Pheobe Denning — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI 3
16. SOCIAL SECURITY NO.: 518-26-8037
17. INFORMANT'S OWN SIGNATURE: Joyce Hunkins — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Artery Disease
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Cerebral Thrombosis

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1964, *to* 7-14, 1967, *that I last saw the deceased alive on* 7-13, 1967, *and that death occurred at* ____ m. *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 263 (Degree or title)
23b. ADDRESS: Salmon Idaho
23c. DATE SIGNED: 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 17, 1967	Salmon	Salmon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-67	Viola E. Johnson	Delbert H. Jones	E-369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3160
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: Monterey
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salinos 555
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Brian	Scott	Boundy	7	15	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	never married	April 18, 1962	5				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Buffalo, New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald R. Boundy — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Margaret Gage — BIRTHPLACE: Nevada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Margaret Cantero

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) asphyxiation by drowning — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Salmon river 18
21c. (CITY, TOWN, OR TOWNSHIP): Salmon 13 — (COUNTY): 388 Lemhi — (STATE): Idaho
21d. TIME OF INJURY (Month): 7 (Day): 15 (Year): 67 (Hour): m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? child waded into river, swept away

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Delbert C. Jones 583 Lemhi Co	Coroner 17	Salmon, Idaho	7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
burial	7-20-67	Garden Memory	Salinos	California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-67	Viola E. Johnson	Delbert C. Jones	E-369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-62021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 7 1986

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3161
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 135
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LIMITS OF TOWN (in this place): 35 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casabello Estate 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon 300
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Stuart
b. (Middle):
c. (Last): Lee, (Senior)

4. DATE OF DEATH (Month) (Day) (Year): July 15, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 27, 1881
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Woodruff, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Dr. Ezekiel Lee — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Adelaide Dickson — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 516-16-8906 A
17. INFORMANT'S OWN SIGNATURE: Donna Wilson — ADDRESS: Drummond, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2040

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden death prob.
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) due to Heart,
DUE TO (c) Chronic lymphatic Leukemia 6 mo
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Benign Prost hypertrophy 6 mos.

INTERVAL BETWEEN ONSET AND DEATH: 0 -

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1949, 19__, *to* July 15 1967, *that I last saw the deceased alive on* June 21, 1967, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. W. Marshall M.D. 045
23b. ADDRESS: Salmon, Ida
23c. DATE SIGNED: 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-18-67
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: 7-19-67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E 369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM; in case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3162
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 300
a. COUNTY Lemhi 130
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
c. LENGTH OF STAY (in this place) 30 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon 300
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Thomas b. (Middle) Franklin c. (Last) Piatte

4. DATE OF DEATH (Month) July (Day) 19 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 4, 1880
9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) wood hauler-contract
10b. KIND OF BUSINESS OR INDUSTRY work 27
11. BIRTHPLACE (State or foreign country) Scioto, Ohio
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas F. Piatte BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Sarah Jones BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Howard Taylor - Salmon ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1538 Intestional obstruct — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Prob. unknown neoplasm —

DUE TO (c) of large intestion —

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Arterio sclerotic Cerebro vasc disease 10 yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1949, to July 19, 1967 that I last saw the deceased alive on July 19, 1967, and that death occurred at 4:45 m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 045 [signature] M.D.
23b. ADDRESS Salmon, Ida
23c. DATE SIGNED 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-22-67
24c. NAME OF CEMETERY OR CREMATORY Salmon
24d. LOCATION (City, town, or county) (State) Salmon, Idaho

DATE REC'D BY LOCAL REG. Aug 2nd 67
REGISTRAR'S SIGNATURE Viola E. Johnson
25. EMBALMER Delbert C. Jones
LICENSE NO. E 369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3163
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO. AUG - 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 300 Lemhi 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
c. LENGTH OF STAY (in this place) d.o.a.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Steele Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 091 Pocatello
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Kenneth b. (Middle) 000 c. (Last) Lee Van Sickle

4. DATE OF DEATH (Month) (Day) (Year) July 21 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Oct. 23, 1928

9. AGE (In years last birthday) 38
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equip. Opprator //

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Ashton, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert W. Van Sickle
BIRTHPLACE Org.

14. MOTHER'S MAIDEN NAME Sarah Daw
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 26 3564

17. INFORMANT'S OWN SIGNATURE L. Van Sickle ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary artery disease - 3 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH [redacted]

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE [redacted] 263 (Degree or title)

23b. ADDRESS [redacted] Salmon Idaho

23c. DATE SIGNED 7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 7-21-67

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. July 28-67

REGISTRAR'S SIGNATURE Viola E. Johnson

25. EMBALMER body not embalmed
LICENSE NO.

FIRM NAME: Manning [redacted] Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3164
Local Reg. No. 690
Reg. Dist. No.

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 14 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL Pine Creek - Shoup
c. LENGTH OF STAY (in this place): 2 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Logging Road near Shoup

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 300 Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Michael
b. (Middle): 000 Benjamin
c. (Last): Callahan

4. DATE OF DEATH (Month) 7 (Day) 31 (Year) 67

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: April 4, 1945
9. AGE (In years last birthday): 22 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): logger 17
10b. KIND OF BUSINESS OR INDUSTRY: logging
11. BIRTHPLACE (State or foreign country): San Diego, California
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Benjamin Callahan — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Jean Atkinson — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 10-13-65 5-18-67
16. SOCIAL SECURITY NO.: 538-44-0629
17. INFORMANT'S OWN SIGNATURE: Mrs Mike O'Farrell — ADDRESS: Salmon, Ida

18. CAUSE OF DEATH 976 X 8
Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): self inflicted gun shot wound in head

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 2 suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 12 Pine Creek - Shoup
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 near Salmon 300 Lemhi Idaho
21d. TIME OF INJURY (Month) 7 (Day) 31 (Year) 67 (Hour) 3 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from ——, 19—, to ——, 19—, that I last saw the deceased alive on ——, 19—, and that death occurred at —— m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 583 Delbert C Jones Lemhi Co. Coroner 4
23b. ADDRESS: Salmon, Idaho
23c. DATE SIGNED: 8-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: Salmon Cemetery
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Aug 10 - 67
REGISTRAR'S SIGNATURE: Viola E Johnson
25. EMBALMER: Delbert C Jones
LICENSE NO.: F-369

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3165
Local Reg. No.
Reg. Dist. No.

RECEIVED Certificate of Death

STATE OF IDAHO

BIRTH NO.

JUL 27 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lewis 310 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
c. LENGTH OF STAY (in this place): 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home in Kamiah 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah 310
d. STREET ADDRESS (If rural, give location): Kamiah, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) ARTHUR b. (Middle) LEWIS c. (Last) SORWEIDE

4. DATE OF DEATH: (Month) July (Day) 11, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Oct 27, 1920

9. AGE (In years last birthday): 46 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Foreman 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Potlatch, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Sorweide — BIRTHPLACE: Colfax, Wash.

14. MOTHER'S MAIDEN NAME: Ethel Kitsmiller — BIRTHPLACE: Cottage Grove, Ore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes | (If yes, give war or dates of service): WW #2 4

16. SOCIAL SECURITY NO.: 519 06 5582

17. INFORMANT'S OWN SIGNATURE: Mrs Emma H Sorweide — ADDRESS: Kamiah, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* July 11, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 12.10 m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Philip E Cross 583 4 Coroner, Lewis Co.

23b. ADDRESS: Craigmont Idaho

23c. DATE SIGNED: 7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: July 1967

24c. NAME OF CEMETERY OR CREMATORY:

24d. LOCATION (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: 7/22/67

REGISTRAR'S SIGNATURE: Viola V. Paup

25. EMBALMER: Robert R. Hanson Hanson

LICENSE NO.: E 433

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Rev.

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3166
Local Reg. No. 33
Reg. Dist. No. 630

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331 JUL 21 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (If not in place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Burton 330
d. STREET ADDRESS (If rural, give location): Rt. 1 Rexburg

3. NAME OF DECEASED (Type or Print)
a. (First): HILMER
b. (Middle): VALENTINE 123
c. (Last): JANSON

4. DATE OF DEATH (Month) (Day) (Year): July 1, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Nov. 24, 1879
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sandy, Utah
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Gustave Janson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Augusta Carlson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-40-3385
17. INFORMANT'S OWN SIGNATURE: Ida A Barnes — ADDRESS: Menan, Idaho

18. CAUSE OF DEATH 4341
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 18 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Gastro-intestinal bleeding — 2 months
Cause not determined - Age

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb, 1955, *to* July 1, 1967, *that I last saw the deceased alive on* July 1, 1967, *and that death occurred at* 7:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Blaine H Passey 409 (Degree or title): MD
23b. ADDRESS: Rexburg, Idaho
23c. DATE SIGNED: 7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/5/67
24c. NAME OF CEMETERY OR CREMATORY: Burton
24d. LOCATION (City, town, or county): Madison (State): Idaho

DATE REC'D BY LOCAL REG.: 7-5-67
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Kenneth Flamm
LICENSE NO.: E347

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3167
Local Reg. No. 24
Reg. Dist. No. 630

BIRTH NO.

RECEIVED STATE OF IDAHO
JUL 21 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN: Rexburg
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg 331
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Daniel	Wells	Grover	July	2,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Widowed 2	April 8, 1876	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Dairyman	04	Nephi, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Grover	Nauvoo, Illinois	Elizabeth Heiner	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		518-10-6456A	Wells Grover	Rexburg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days
Probable Hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus - Age

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug, 1961, *to* July 2, 1967, *that I last saw the deceased alive on* July 2, 1967, *and that death occurred at* 11:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Blaine A Dorsey	MD	Rexburg Idaho	7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/6/67	Rexburg	Rexburg Madison Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-6-67	Leona Flamm	James R Flamm	E-477

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3168
Local Reg. No. 96
Reg. Dist. No. 630

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Madison Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg 331
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Kenneth b. (Middle) 123 c. (Last) Webster

4. DATE OF DEATH (Month) July (Day) 12, (Year) 1967

5. SEX Male

6. COLOR OR RACE Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH January 27, 1919

9. AGE (In years last birthday) 48 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Dry Farm

11. BIRTHPLACE (State or foreign country) Logan, Utah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Kenneth Smart Webster BIRTHPLACE Wilford, Idaho

14. MOTHER'S MAIDEN NAME Lola Merrill BIRTHPLACE Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-12-0944

17. INFORMANT'S OWN SIGNATURE Lola M. Webster ADDRESS Rexburg Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction 4280 — INTERVAL BETWEEN ONSET AND DEATH 10 da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan, 1965, to 7-12, 1967, that I last saw the deceased alive on 7-12, 1967, and that death occurred at 835 m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title) Lester Peterson MD

23b. ADDRESS Rexburg Ida

23c. DATE SIGNED 7-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/14/67

24c. NAME OF CEMETERY OR CREMATORY Sugar City Cemetery

24d. LOCATION (City, town, or county) (State) Sugar City, Madison, Idaho

DATE REC'D BY LOCAL REG. 7-14-67

REGISTRAR'S SIGNATURE Leona Flamm

25. EMBALMER James R. Flamm LICENSE NO. E 477

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 28 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 11 1967

SEP 26 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

AUG 1 1968

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

SEP 18 1968

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3169
Local Reg. No. 96
Reg. Dist. No. 630

BIRTH NO.

JUL 21 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN: Rexburg
STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Madison Memorial Hosp. 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN: St Anthony 221
d. STREET ADDRESS (If rural, give location): RFD 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Helen	Niederer	Palmer	July 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Cauc.	Married 3	Nov. 24, 1921	45		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Archer, Madison Co. Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Rulon Niederer	South Cottonwood, SL Co. Utah	Vada R. Nielsen	Koosharem, Piute Co, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Glenus Palmer	St. Anthony RFD 2

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial infarction 4201

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1965, *to* July 12, 1967, *that I last saw the deceased alive on* July 12, 1967, *and that death occurred at* 12 30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ray R. Mabey 317	MD	Rexburg Idaho	7-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/15/67	Parker Cemetery	Parker, Fremont, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-15-67	Lena Flamm	Russel Flamm	E-254

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3170
Local Reg. No. 37
Reg. Dist. No. 630

RECEIVED Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Madison 33 | JUL 21 1967 | 3-03
b. CITY OR TOWN Rexburg | LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Madison Memorial 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Jefferson
c. CITY OR TOWN Rigby 260
d. STREET ADDRESS (If rural, give location) 182 East 1st North

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) ACE c. (Last) (CAP) PASSEY

4. DATE OF DEATH (Month) (Day) (Year) July 13, 1967

5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3 | 8. DATE OF BIRTH June 6, 1887 | 9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Lanark, Idaho.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William T. Passey | BIRTHPLACE ?
14. MOTHER'S MAIDEN NAME Lydia Toomer | BIRTHPLACE Morgan, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-42-8097
17. INFORMANT'S OWN SIGNATURE Floyd Ray Passey | ADDRESS Rte. 4 Rigby, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus - mild — 6 mos

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1963, to July 13, 1967, that I last saw the deceased alive on July 12, 1967, and that death occurred at 12:01 A.M., from the causes and on the date stated above.

23a. SIGNATURE Blaine H. Passey 409 (Degree or title) M.D.
23b. ADDRESS 90 S. 1st West Rexburg, Idaho.
23c. DATE SIGNED 7-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 15, 1967
24c. NAME OF CEMETERY OR CREMATORY Little Butte
24d. LOCATION (City, town, or county) (State) Annis Jefferson Idaho

DATE REC'D BY LOCAL REG. 7-15-67
REGISTRAR'S SIGNATURE Leona Flamm
25. EMBALMER Bruce A. Eckersell
LICENSE NO. E-404
FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3171
Local Reg. No. 38
Reg. Dist. No. 630

BIRTH NO. 331 307

1. PLACE OF DEATH
a. COUNTY: Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Archer 330
d. STREET ADDRESS (If rural, give location): Thornton Rt. 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LEAH	OAKLEY	SMOUT WEEKES	July 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed 2	Feb. 13, 1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Slatersville, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Felix Smout	England	Sarah Theresa Baird	Brigham City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		none	Melva W. Grover	Thornton Rt. 1

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4280

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 20 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7 *,* 19 64 *to* 7-19 *,* 19 67 *that I last saw the deceased alive on* 7-19 *,* 19 67 *, and that death occurred at* 11 30 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ray A. Mabey	317 MD	Rexburg Idaho	7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/22/67	Sutton	Archer Madison Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-21-67	Leona Flamm	Russell Flamm	347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED — STATE OF IDAHO

State File No. 3172
Local Reg. No. 58
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340 JUL 20 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give): Rupert
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert 340
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOSEPH	ALFRED	JENKS	July 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct. 28, 1889	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	North Ogden, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Wallace Jenks		Annie S. Randall	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Eugene A. Jenks	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of stomach — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct. *,* 1966 *, to* July *,* 1967 *, that I last saw the deceased alive on* July 10 *,* 1967 *, and that death occurred at* 5:00 A. m. *, from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hall Crawford	740 M.D.	Rupert, Idaho	7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7-17-67	Manning Funeral Chapel	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-17-67	Mary Ellen Barlow	Conway Grant	E478

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 18 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3173
Local Reg. No. 59
Reg. Dist. No. 420

BIRTH NO.

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert 340
d. STREET ADDRESS (If rural, give location) 824 E Street

3. NAME OF DECEASED (Type or Print) a. (First) Myrtle b. (Middle) c. (Last) Poindexter

4. DATE OF DEATH (Month) (Day) (Year) 7-22-67

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 5-19-1892
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife
10b. KIND OF BUSINESS OR INDUSTRY 01
11. BIRTHPLACE (State or foreign country) Bates County Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thadius Brunner
BIRTHPLACE Louisville Kentucky
14. MOTHER'S MAIDEN NAME Ellen Gillespie
BIRTHPLACE not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none 0
16. SOCIAL SECURITY NO. 519-28-0693
17. INFORMANT'S OWN SIGNATURE X Mrs Juanita Holbrook
ADDRESS Homedale

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1993

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 2 mo. ±

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Unknown.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1962, *to* 7-22, 1967, *that I last saw the deceased alive on* 7-22-67, 19___, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE Ben C. Humphrey MD 253 (Degree or title)
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 7-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-25-1967
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho Minidoka County

DATE REC'D BY LOCAL REG. 8-1-67
REGISTRAR'S SIGNATURE Mary Ellen Larson
25. EMBALMER Robert C Walk
LICENSE NO. E 294
FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3174
Local Reg. No. 159
Reg. Dist. No. 220

RECEIVED

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 — JUL 12 1967 — 102
b. CITY OR TOWN: Lewiston — Bureau of Vital Statistics — LENGTH OF STAY: 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Somerville Nursing Home 131

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston — 351
d. STREET ADDRESS (If rural, give location): 1304 - 'F' Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARGARET	S.	FOGG	2 July 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	15 Aug. 1882	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner-Operator 22	Hotel	Livingston, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Sommers	Wisc.	Florence Merriman	Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		519 52 8265	Jeannette E. Merriman	Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4918 Bronchopneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiac Decompensation

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5/8/ 1965, *to* 7/2/ 1967, *that I last saw the deceased alive on* 9/1/ 1966, *and that death occurred at* 3:45 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
507 [illegible], MD	939 Bryden Ave., Lewiston, Ida.	7/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	5 July 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-6-67	Lynette Knott	W. E. Black — Malcom's Brower-Wann Memorial Chapel	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3175
Local Reg. No. 161
Reg. Dist. No. 220

RECEIVED JUL 19 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) S. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston 351
d. STREET ADDRESS (If rural, give location) 1712-8th Avenue

3. NAME OF DECEASED (Type or Print) a. (First) Fernie b. (Middle) M c. (Last) Charpentier

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Oct. 12, 1890

9. AGE (In years last birthday) 76
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook 01

10b. KIND OF BUSINESS OR INDUSTRY restaurant

11. BIRTHPLACE (State or foreign country) Iowa

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Fred Sweeney
BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME Melvina Gotche
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 543-26-4003A

17. INFORMANT'S OWN SIGNATURE Bernice A. Riggers
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis — INTERVAL BETWEEN ONSET AND DEATH 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Perforated retrocecal appendix
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Possible Gas Gangrene of Cecal area

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/2/67, 19___, *to* 7/3/67, 19___, *that I last saw the deceased alive on* 7/3/67, 19___, *and that death occurred at* 7:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE Don Glover (Degree or title) MD

23b. ADDRESS 939 Bryden Ave., Lewiston, Idaho

23c. DATE SIGNED 7/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3

24b. DATE July 7, 1967

24c. NAME OF CEMETERY OR CREMATORY Pendleton, Oregon

24d. LOCATION (City, town, or county) (State) Pendleton, Oregon

DATE REC'D BY LOCAL REG. 7-6-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER D. Vasser

LICENSE NO. E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3176
Local Reg. No. 166
Reg. Dist. No. 220

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: NezPerce 351 JUL 19 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 3329 - 8th Street 'A'

3. NAME OF DECEASED (Type or Print): a. (First) DOUGLAS b. (Middle) RICHARD c. (Last) HARVEY

4. DATE OF DEATH: (Month) (Day) (Year): 3 July 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify): Never Married

8. DATE OF BIRTH: 11 June 1952

9. AGE (In years last birthday): 15 IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: Jr. Hi-Sch.

11. BIRTHPLACE (State or foreign country): Clarkston, Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Floyd Harvey — BIRTHPLACE: Lewiston, Ida.

14. MOTHER'S MAIDEN NAME: Doris Palmer — BIRTHPLACE: Culdesac, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 56 2465

17. INFORMANT'S OWN SIGNATURE: Doris C. Harvey — ADDRESS: Lewiston, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Tamponade. — INTERVAL BETWEEN ONSET AND DEATH: 1 minute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Pulmonary hypertension — Life
DUE TO (c): Pulm. Vasc Disease, Mitral stenosis and VSD. — Life.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Neil Mannebach 325 (Degree or title): MD — **23b. ADDRESS**: Lewiston Idaho — **23c. DATE SIGNED**: 7-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 5 July 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Lewis-Clark Memo. Gard. — **24d. LOCATION** (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-10-67 — REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: W E Black — Malcom's Brower-Wann Memorial Chapel — LICENSE NO.: E-426

FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3177
Local Reg. No. 164
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 351 JUL 19 1967 323
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) 23 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Josephs Hosptial 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston 351
d. STREET ADDRESS (If rural, give location) 1934 Cedar Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) HUGH
b. (Middle)
c. (Last) MOOR

4. DATE OF DEATH (Month) (Day) (Year) 4 July 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH 14 Nov. 1896
9. AGE (In years last birthday) 70 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Section Foreman 26
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Golden City, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjiman Harrison
BIRTHPLACE Penna.
14. MOTHER'S MAIDEN NAME Melisia K. Bishop
BIRTHPLACE Penna

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 701 07 6677
17. INFORMANT'S OWN SIGNATURE Ermyth Nichols
ADDRESS Reubens, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Bronchopneumonia 154X
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cancer of rectum
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 26, 1967, *to* July 4, 1967, *that I last saw the deceased alive on* June 12, 1967, *and that death occurred at* 5:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE R. M. Stover, M.D. 507 (Degree or title)
23b. ADDRESS 939 Bryden Ave., Lewiston, Idaho
23c. DATE SIGNED 7/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8 July 1967
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 7-7-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER K. H. Malcom
LICENSE NO. E276
Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3178
Local Reg. No. 168
Reg. Dist. No. 220

RECEIVED JUL 19 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
STATISTICS OF STAY (in this place): Residence
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 913 Warner Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	MEDA	ELVIRA	SLOCUM	4	July	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months	Days	If UNDER 24 HRS.: Hours	Min.
Female	White	Married 3	6 Feb. 1892	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Comstock, Nebr.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jackson Bailey	Nebr.	Lillian Pierce	Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518 16 2394	H M Slocum	Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 2+ yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Chronic Asthmatic Bronchitis — 10+ yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diffuse arteriosclerosis. — 2+ yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct 1965 *to* July, 1967, *that I last saw the deceased alive on* June 7, 1967, *and that death occurred at* 2 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R R Stein	496 MD	Lewiston Idaho	10 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7 July 1967	Lewis-Clark Memo. Gard.	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-11-67	Lynette Knott	K. H. Malcom — Malcom's Brower-Wann Memorial Chapel	E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3179
Local Reg. No. 165
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 351 Nez Perce — JUL 19 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give name of township): Lewiston (Rural) — Burrell
c. LENGTH OF STAY in this place: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1310- Burrell 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston (Rural) 351
d. STREET ADDRESS (If rural, give location): 1310- Burrell

3. NAME OF DECEASED (Type or Print): a. (First) May — b. (Middle) — c. (Last) Bowles

4. DATE OF DEATH: (Month) July (Day) 5 (Year) 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 13, 1894

9. AGE (In years last birthday): 73 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife 01

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Spokane, Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: NO RECORD — BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: NO RECORD — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: No record

17. INFORMANT'S OWN SIGNATURE: X Arthur J Bowles — ADDRESS: Lewiston, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro vascular insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 4-5 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Atrial fibrillation & cerebral embolism — 6 mo.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Hemiplegia — 1 year

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept, 1966, *to* March, 1967, *that I last saw the deceased alive on* March 25, 1967, *and that death occurred at* 7P m., *from the causes and on the date stated above.*

23a. SIGNATURE: R R Stern 496 (Degree or title) MD — **23b. ADDRESS**: Lewiston, Ida. — **23c. DATE SIGNED**: 7 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 7-8-1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Lewis-Clark Memorial Gardens, Lewiston, Idaho. — **24d. LOCATION** (City, town, or county) (State):

DATE REC'D BY LOCAL REG.: 7-7-67 — **REGISTRAR'S SIGNATURE**: Lynette Knott

25. EMBALMER: Andrew F. Vassar — **LICENSE NO.**: E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3180
Local Reg. No. 167
Reg. Dist. No. 220

RECEIVED JUL 19 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Nez Perce 351 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston — c. LENGTH OF STAY (in this place): 1 day — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Lewis — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rt. 1 Craigmont 310 — d. STREET ADDRESS (If rural, give location): Rt. 1 Craigmont

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HARRY	A.	BROKER	July 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	11-18-1895	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04 — **10b. KIND OF BUSINESS OR INDUSTRY**: Farming

11. BIRTHPLACE (State or foreign country): Lincoln, Kansas — **12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

13. FATHER'S NAME: Harry P. Broker — BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Angela Nelson — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Naomi Broker — ADDRESS: Craigmont, Id.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acut pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Aortic stenosis

DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hemorrhage large bowel

19a. DATE OF OPERATION — **19b. MAJOR FINDINGS OF OPERATION**: Blood in large bowel, liver congestion — **20. AUTOPSY?** YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) — **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) — **21c. (CITY, TOWN, OR TOWNSHIP)** (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — **21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — **21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* May 16, 1967, *to* July 5, 1967, *that I last saw the deceased alive on* July 5, 1967, *and that death occurred at* 10:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C.S. English 160 M.D. — **23b. ADDRESS**: 308 St. Johns Way, Lewiston, Id — **23c. DATE SIGNED**: 7/6/1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7-10-67	I.O.O.F. Cemetery	Craigmont, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-10-67	Lynette Knott	Patrick Mahoney	E-192

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Merchant Funeral Home - Clarkston Washington

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED JUL 19 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3181
Local Reg. No. 170
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 351 217
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 17 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee 290
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Alzina b. (Middle) Rebecca c. (Last) Hayden

4. DATE OF DEATH: (Month) July (Day) 6 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: Feb 13, 1878

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 07

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Story City, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Hamilton
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Melissa Squires
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-22-6666

17. INFORMANT'S OWN SIGNATURE: X [illegible] Hayden
ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4590 Pneumonia (bronchial)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 Days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Feb. 16, 1967, *to* July 6, 1967, *that I last saw the deceased alive on* July 6, 1967, *and that death occurred at* 9:33 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Don Stover (Degree or title) 507 1
23b. ADDRESS: 939 Bryden Ave., Lewiston, Idaho
23c. DATE SIGNED: 7/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Genesee City Cemetery
24d. LOCATION (City, town, or county) (State): Genesee Idaho

DATE REC'D BY LOCAL REG.: 7-13-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

DR BARNES

Certificate of Death

STATE OF IDAHO

State File No. 3182
Local Reg. No. 169
Reg. Dist. No. 220

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Nez Perce — 351 — JUL 19 1967 — 324
b. CITY OR TOWN: Lewiston — c. LENGTH OF STAY (in this place): 24 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital — 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston — 351
d. STREET ADDRESS (If rural, give location): 1407 - 6th Ave

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	PEARL		FITE	July 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	5-16-1880	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homekeeper 01	Own Home	Miami County, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Snyder	Unknown	Amanda Imhoof	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - - - - -	None	Charles Fite Charles Fite	Lewiston, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

584X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 15 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6-29-67	Cholecysto duodenal fistula. Gall stone ileus	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-15, 1967, *to* 7-9, 1967, *that I last saw the deceased alive on* 7-9, 1967, *and that death occurred at* 2:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John F. Barnes 028	M.D.	347 St John, Lewiston Idaho	7-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 12, 67	Lewis-Clark Memorial Gardens	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-12-67	Lynette Knott	Robert Lovelace	802

FIRM NAME: Merchant Funeral Home-Clarkston, Wn.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

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STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG - 1 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3183
Local Reg. No. 177
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 128
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 28 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 323 North Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 323 North Street

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): MORGAN
c. (Last): MONTAGUE

4. DATE OF DEATH (Month) (Day) (Year): July 11, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 4-21-1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Worker 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Stanton, Kentucky
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clinton Montague — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Sadie Combs — BIRTHPLACE: Stanton, Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-01-1817
17. INFORMANT'S OWN SIGNATURE: Mrs. Nein Turner — ADDRESS: Clarkston, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart Attack — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ——, 19__, to ——, 19__, that I last saw the deceased alive on ——, 19__, and that death occurred at 9 A. m., from the causes and on the date stated above.

23a. SIGNATURE: Wilfred J. Duclos 583 (Degree or title): Coroner 4
23b. ADDRESS: Lewiston Idaho
23c. DATE SIGNED: 7-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 7-18-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Patrick Mahoney — LICENSE NO.: E- 492

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Merchant Funeral Home-Clarkston, Wn.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3184
Local Reg. No. 174
Reg. Dist. No. 220

RECEIVED
AUG - 1 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 317
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 17 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Deary 290
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Samuel
b. (Middle): Emil
c. (Last): Anderson

4. DATE OF DEATH (Month) July (Day) 13 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Aug 6, 1893
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Owner 22
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Deary, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Anderson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Augusta Dahlberg — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. 1 3 177 X
16. SOCIAL SECURITY NO.: 519-32-9968
17. INFORMANT'S OWN SIGNATURE: x Goldie Anderson — ADDRESS: Deary, Ida. (Wife)

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastatic Carcinomatosis
DUE TO (c) Cancer of prostate gland

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Heart Failure

INTERVAL BETWEEN ONSET AND DEATH: 10 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Diabetes Mellitus
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 28, 1967, *to* July 13, 1967, *that I last saw the deceased alive on* July 13, 1967, *and that death occurred at* 11:15 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE: R M Stover 507 (Degree or title) MD
23b. ADDRESS: 939 Bryden Ave., Lewiston, Idaho
23c. DATE SIGNED: 7/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 17, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 7-20-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

AUG - 1 1967 STATE OF IDAHO

State File No. 3185
Local Reg. No. 173
Reg. Dist. No. 220

BIRTH NO.

Bureau of Vital Statistics 803

1. PLACE OF DEATH
a. COUNTY: 351 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston (Rural)
c. LENGTH OF STAY (in this place): 3 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Somerville Rest Home 131

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston (Rural) 351
d. STREET ADDRESS (If rural, give location): 1435- Birch Ave

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): Andrew
c. (Last): Chisholm

4. DATE OF DEATH (Month) (Day) (Year): July 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: Aug. 29, 1911
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Night Clerk Bollinger
10b. KIND OF BUSINESS OR INDUSTRY: Hotel 25
11. BIRTHPLACE (State or foreign country): Kellogg Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter Andrew Chislom — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Ruth Huey — BIRTHPLACE: Spokane, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-09-3698
17. INFORMANT'S OWN SIGNATURE: X Mrs. Frank Chisholm — ADDRESS

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1946, *to* July 18, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 4:50 p.m.; *from the causes and on the date stated above.*

23a. SIGNATURE 083 (Degree or title): John E. Cusson M.D.
23b. ADDRESS: 9th & Main Lewiston Idaho
23c. DATE SIGNED: 7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 201967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 7-18-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Andrew F. Vassar
LICENSE NO.: E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3186
Local Reg. No. 172
Reg. Dist. No. 220

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO. AUG - 1 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 NezPerce 149
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) since 1918
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 364 Lapwai Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston 351
d. STREET ADDRESS (If rural, give location) 364 Lapwai Road

3. NAME OF DECEASED (Type or Print)
a. (First) Clarence
b. (Middle) W
c. (Last) Dewey

4. DATE OF DEATH (Month) July (Day) 18 (Year) 1967

5. SEX male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Oct 14 1891
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME no record — BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME no record — BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no record
17. INFORMANT'S OWN SIGNATURE Frances J Carroll — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Circulatory failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Anterior diabetic heart disease — 3 wks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Severe anemia, Anasarca

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-12, 1967, *to* 7-18, 1967, *that I last saw the deceased alive on* 7-12, 1967, *and that death occurred at* 12:40 p. m.; *from the causes and on the date stated above.*

23a. SIGNATURE J. W. Eastwood 152 (Degree or title) Eng D
23b. ADDRESS Lewiston Idaho
23c. DATE SIGNED 7-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 19, 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) Lewiston, Idaho. (State)

DATE REC'D BY LOCAL REG. 7-18-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar
LICENSE NO. E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Eastwood

JUL 16 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3187
Local Reg. No. 177
Reg. Dist. No. 220

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce (351) AUG - 1 1967 (301) — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital (128)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce (351)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 2111 Ridgeway

3. NAME OF DECEASED (Type or Print): a. (First) Leila b. (Middle) Mae c. (Last) Dale

4. DATE OF DEATH: (Month) July (Day) 18 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married (3)

8. DATE OF BIRTH: May 1, 1920

9. AGE (In years last birthday): 47
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife (01)

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bozeman, Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Anthony Tester
BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Maude Anderson
BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: no record

17. INFORMANT'S OWN SIGNATURE: Robert L Dale
ADDRESS: Lewiston

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured aneurysm cerebral artery (330X) — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-17, 1967, *to* 7-18, 1967, *that I last saw the deceased alive on* 7-18, 1967, *and that death occurred at* 3:35a m., *from the causes and on the date stated above.*

23a. SIGNATURE - 502 (Degree or title): Dr. Lyle Mc

23b. ADDRESS: Lewiston, Idaho

23c. DATE SIGNED: 7-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 20 July 1967

24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 7-26-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel

LICENSE NO.: E-295

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 4 1967

JUL 2 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3188
Local Reg. No. 177
Reg. Dist. No. 220

BIRTH NO.

AUG - 1 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 35 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston 35
d. STREET ADDRESS (If rural, give location) 1402-G. St

3. NAME OF DECEASED (Type or Print) a. (First) Ralph b. (Middle) c. (Last) Killinger

4. DATE OF DEATH (Month) July (Day) 19 (Year) 1967

5. SEX male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH 9-19-1895

9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Elmira Penn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME no record — BIRTHPLACE

14. MOTHER'S MAIDEN NAME no record — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 548-05-0640

17. INFORMANT'S OWN SIGNATURE Hospital records — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis

332X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18-, 1967, *to* July 19, 1967, *that I last saw the deceased alive on* [illegible] 19, 19[illegible], *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23a. SIGNATURE L. Cusmon 114 (Degree or title) M.D.

23b. ADDRESS 342 St Joseph Way

23c. DATE SIGNED 7 26 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-26-1967

24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery

24d. LOCATION (City, town, or county) Lewiston, Idaho. (State)

DATE REC'D BY LOCAL REG. 7-26-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER V. Vassar

LICENSE NO. E 297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3189
Local Reg. No. 175
Reg. Dist. No. 220

BIRTH NO.

AUG - 1 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston 351
d. STREET ADDRESS (If rural, give location) 204-22nd St.

3. NAME OF DECEASED (Type or Print) a. (First) Ethell b. (Middle) May c. (Last) Powell

4. DATE OF DEATH (Month) (Day) (Year) July 19, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH July 22, 1894

9. AGE (In years last birthday) 72
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) houw3wife 01

10b. KIND OF BUSINESS OR INDUSTRY at home

11. BIRTHPLACE (State or foreign country) Milton, Oregon

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME William Crow
BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Katherine Batz
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE James A. Powell
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 4 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 12:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE John E. Casson 083 (Degree or title)

23b. ADDRESS 94 Main Lewiston Idaho

23c. DATE SIGNED 7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal

24b. DATE July 21, 1967

24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery

24d. LOCATION (City, town, or county) Apokane, Washington (State)

DATE REC'D BY LOCAL REG. 7-20-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER V. Vasser

LICENSE NO. E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Cassaw

AUG 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept. 15, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3190
Local Reg. No. 176
Reg. Dist. No. 220

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 350
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hi-Way U.S.12, 2 miles West
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): of Myrtle Beach, Idaho 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Franklin 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasco
d. STREET ADDRESS (If rural, give location): 1119 W. Hopkins

3. NAME OF DECEASED (Type or Print): a. (First) Gordon; b. (Middle) M.; c. (Last) Aasen

4. DATE OF DEATH: (Month) July (Day) 21, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: March 30, 1918

9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Driller

10b. KIND OF BUSINESS OR INDUSTRY: Dam Construction

11. BIRTHPLACE (State or foreign country): South Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edwin Aasen — BIRTHPLACE: South Dakota

14. MOTHER'S MAIDEN NAME: Bothilda (no record) — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no record — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 331 20 7252

17. INFORMANT'S OWN SIGNATURE by W. E. Blac ADDRESS: Mary Aasen (via telephone) Pasto, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Drowning
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): US Hi-way #1206
21c. (CITY, TOWN, OR TOWNSHIP) 13 Myrtle (COUNTY) 350 Nez Perce (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): July 21, 1967-6:45pm
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 2-car accident, auto going into the Clearwater River

22. *I hereby certify that I attended the deceased from ----------, 19---, to ----------, 19---, that I last saw the deceased alive on ----------, 19---, and that death occurred at 6:45pm., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Duclos, Nez Perce Co. Coroner (Degree or title) 583 4
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: July 22, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: July 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Bruce Lee Memo. Chapel
24d. LOCATION (City, town, or county) (State): Pasco, Franklin co., Wash.

DATE REC'D BY LOCAL REG.: 7-22-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: K. H. Malcom
LICENSE NO.: E-376
FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
SEP 15 1967
Bureau of Vital Statistics

State of Washington } ss.
County of Franklin }

Certificate No. 67-3190

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death for Gordon M. Aasen (Name on Original Certificate) who died (Was Born or Died) on July 21, 1967 (Date of Event) in Nez Perce County, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#2d -Street Address	217 West Clark	1119 W. Hopkins

Subscribed and sworn to before me this 8th day of September, 1967

Notary Public, residing at Pasco

My commission expires Dec 10, 1968

(Seal)

Signed Mary Aasen

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

1119 West Hopkins, Pasco, Wash.

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Washington } ss.
County of Franklin }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 8th day of September, 1967

Notary Public, residing at Pasco

My commission expires Dec 10, 1968

(Seal)

Signed Georgianna Patterson

(Signature of Any Credible Person)

1124 Hopkins, Pasco, Wash.

(Street Address, City, State)

FORM DH 60-155

L. 9-7-67 AP

Affidavit to Correct or Amend A[illegible] Date of Birth or Death

Statement [illegible] 67-3190

County of [illegible]

[illegible] death

Gordon M. Aasen died July 21, 1967

Nez Perce County, Idaho

[illegible] of his knowledge, the

are:

[illegible] Street Address 217 West Clark 1119 W. Hopkins

[illegible] day of

[illegible] correction [illegible]

[illegible] Pasco, Wash.

SUPPORTING AFFIDAVIT OF A SECOND PERSON

Statement [illegible]

[illegible]

[illegible] Pasco, Wash.

[illegible] Dec. 10, 1968

[illegible] Pasco, Wash.

RECEIVED
AUG - 1 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3190
Local Reg. No. 176
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hi-Way #U.S.12, 2 miles West
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): of Myrtle Beach, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasco
d. STREET ADDRESS (If rural, give location): 217 West Clark

3. NAME OF DECEASED (Type or Print): a. (First) GORDON; b. (Middle) M.; c. (Last) AASEN

4. DATE OF DEATH: (Month) 21 July (Day) (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 30 March 1918

9. AGE (In years last birthday): 49
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Driller

10b. KIND OF BUSINESS OR INDUSTRY: Dam Construction

11. BIRTHPLACE (State or foreign country): South Dakota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edwin Aasen
BIRTHPLACE: South Dakota

14. MOTHER'S MAIDEN NAME: Bothilda (no record)
BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no record

16. SOCIAL SECURITY NO.: 331 20 7252

17. INFORMANT'S OWN SIGNATURE: Mary Aasen (via Telephone)
ADDRESS: Pasco, Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Drowning

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): US Hi-Way #12

21c. (CITY, TOWN, OR TOWNSHIP) Myrtle (COUNTY) NezPerce (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 21 July 1967 6:45PM

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? 2-Car Accident, auto going into the Clearwater River.

22. *I hereby certify that I attended the deceased from* - - - - - 19 - -, *to* - - - - - 19 - -, *that I last saw the deceased alive on* - - - - - 19 - -, *and that death occurred at* 6:45 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): NezPerce Co. Coroner
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 22 July 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 22 July 1967
24c. NAME OF CEMETERY OR CREMATORY: Bruce Lee Memo. Chapel
24d. LOCATION (City, town, or county) (State): Pasco, Franklin Co., Wash.

DATE REC'D BY LOCAL REG.: 7-22-67
REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: K. H. Malcom
Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-376

FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 10 1967

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3191
Local Reg. No. 190
Reg. Dist. No. 220

BIRTH NO.

RECEIVED
351 AUG 18 1967 312
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 2026 2nd. Ave. North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Henry	NMI	Dehning	July	21	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	February 23, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railroad Emp.
10b. KIND OF BUSINESS OR INDUSTRY: 10
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Dehning — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Marie Bauck — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-10-6306A
17. INFORMANT'S OWN SIGNATURE: Dick a Dehning — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

163X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Lung c Hemoptysis — INTERVAL BETWEEN ONSET AND DEATH: 3yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: C H Bladder — 4yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-9, 1962, *to* 7-10, 1967, *that I last saw the deceased alive on* 7-21-1967 *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward M. Johnson 238 1	347 St Johns Way Lewis	28 Jul 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	24 Jul 1967	Lewis-Clark Memorial Gardens	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-15-67	Lynette Knott	K.H. Malcom	E-376

Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME:

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3192
Local Reg. No. 178
Reg. Dist. No. 220

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Nez Perce 351 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston — c. LENGTH OF STAY (in this place): 3 days — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: XXXXXX Idaho — b. COUNTY: Nez Perce 303 — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lapwai, Idaho 350 — d. STREET ADDRESS (If rural, give location): Lapwai

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Harrison		Jabeth Sr.	July	21	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Indian	Widowed 2	August 3, 1895	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04	Farming	Kamiah, Ida.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Jabeth		Sarah	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes		518-12-3960	Josephine Parsons	Lewiston

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Congestive Heart Failure 4341	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 6, 1967, *to* July 21, 1967, *that I last saw the deceased alive on* July 21, 1967, *and that death occurred at* 2:4 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
051 [signature]	Lewiston, Idaho	7-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-25-67	Spalding Memorial Cem.	XXXXXXXXX Spalding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-27-67	Lynette Knott	L.E. DeBaun	E-295
		FIRM NAME: Malcom's Brower-Wann Memorial Chapel	

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

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(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 9 - 1967 Bureau of Vital Statistics

State File No. 3193
Local Reg. No. 187
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 4 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: ~~Idaho~~ Wash. 48
b. COUNTY: Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston 555
d. STREET ADDRESS (If rural, give location): 538 - Riverview

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RETTA	ANN	PUCKETT	22 July 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	28 October 1886	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Lexington, Ky.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James H. Bryant	no record	Elizabeth Oldfield	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.		538 16 0362A	Ethel M. Palmer	Arlington, Virginia

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March, 19 67, *to* July, 1967, *that I last saw the deceased alive on* 22 July, 1967, *and that death occurred at* 11:59PM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B O Stem 496	MD	Lewiston, Idaho	27 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	26 July 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-1-67	Lynette Knott	W E Black Malcom's Brower-Wann Memo. Chapel	E-426

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 10 1967

MAR 17 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 21 2006

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

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ADDITIONAL REMARKS by Physician.....

State File No. 3194
Local Reg. No. 182
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 351 AUG 9 - 1967
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 631 Preston

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIE
b. (Middle): EUGENE
c. (Last): PARSLEY

4. DATE OF DEATH (Month) (Day) (Year): 23 July 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 22 Aug. 1895
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Stock-Grain
11. BIRTHPLACE (State or foreign country): Wagner, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Eli Parsley — BIRTHPLACE: Mississippi
14. MOTHER'S MAIDEN NAME: Alice Jane Boatright — BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW-1
16. SOCIAL SECURITY NO.: 518 03 8944A
17. INFORMANT'S OWN SIGNATURE: Elizabeth E. Parsley — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH 5020
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Emph. — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Laserna — 0
DUE TO (c): Chronic Bronchitis — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1951, 19 1, *to* date, 19 ___, *that I last saw the deceased alive on* 7/22, 19 67, *and that death occurred at* 5:27 AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Salem A. Rogers 446 MD
23b. ADDRESS: Clarkston, Wash
23c. DATE SIGNED: 7/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 25 July 1967
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gardens
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-1-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: W E Black — LICENSE NO. E-426
Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

67-7007 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3195
Local Reg. No. 187
Reg. Dist. No. 220

BIRTH NO.

AUG 1 8 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 wk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 3626 - 16th Street

3. NAME OF DECEASED (Type or Print)
a. (First): STEVEN
b. (Middle): DOYLE
c. (Last): LAWS

4. DATE OF DEATH (Month) (Day) (Year): 24 July 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: 17 July 1967
9. AGE (In years last birthday): - - - - | IF UNDER 1 YEAR Months: - | Days: 7 | IF UNDER 24 HRS. Hours: - | Min.: -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 00 02
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clarence Laws
BIRTHPLACE: Orofino, Idaho
14. MOTHER'S MAIDEN NAME: Shirley Weddle
BIRTHPLACE: Durango, Colo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: Clarence E. Laws
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7545

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Insufficiency

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Pre Mature Delivery
DUE TO (c): Wt 2#7 3

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: W.S. Pierce MD 420 (Degree or title)
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 8/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 27 July 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-7-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L E DeBaun
Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 2196
Local Reg. No. 182
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 AUG 18 1967 202
b. CITY OR TOWN: Lewiston
c. LENGTH OF STAY IN THIS PLACE: 2 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN: Lewiston 351
d. STREET ADDRESS (If rural, give location): 414 - 17th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ANDREW	HUDSON	MARTIN	27 July 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	31 August 1879	87		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Construction	Nebo, Illinois	USA

13. FATHER'S NAME — BIRTHPLACE

14. MOTHER'S MAIDEN NAME — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519 09 3061A	Minnie Martin	Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Cardio Renal Vascular Disease	2 yrs.
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 10:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John E Caisson 083	M.D.	9th & Main Lewiston Idaho	8/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	29 July 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-7-67	Lynette Knott	L. E. DeBaun	E-295

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3197
Local Reg. No. 183
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 351 AUG 9 - 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (If this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA - St Josephs Hospital 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston 351
d. STREET ADDRESS (If rural, give location): 1514 Grelle Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): (NMI)
c. (Last): SKIPPER

4. DATE OF DEATH (Month) (Day) (Year): 29 July 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 1 August 1902
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Refinery - Shell Oil Co. 30
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Evansville, Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Skipper — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Lena Seitz — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW-2 4
16. SOCIAL SECURITY NO.: 556 01 5142A
17. INFORMANT'S OWN SIGNATURE: Clinton H Skipper — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/0X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Myocardial - failure — 6 mo.
DUE TO (c): Metrol vehicle Ht disease — yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* July 29, 1967, *that I last saw the deceased alive on* July 28, 1967, *and that death occurred at* 5:32 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph E Boeding MD 022
23b. ADDRESS: 1522 Mtn St City
23c. DATE SIGNED: Aug 1st 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 2 Aug. 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-4-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: W E Black — Maldom's Brower-Wann Memorial Chapel
LICENSE NO.: E426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 13 1995

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3198
Local Reg. No. 180
Reg. Dist. No. 22c

BIRTH NO.

RECEIVED
AUG 9 - 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston (Rural)
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchard Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston (Rural) 351
d. STREET ADDRESS (If rural, give location) 1431-Airway

3. NAME OF DECEASED (Type or Print) a. (First) Anna b. (Middle) C. c. (Last) Schwegel
4. DATE OF DEATH (Month) July (Day) 29 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widored 2
8. DATE OF BIRTH April 1, 1892
9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Chicago, Ill.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME M. Hecker BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Christine Oenning BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 323-01-0062
17. INFORMANT'S OWN SIGNATURE + Margaret Green ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Decompensation — Sudden
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile Dementia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 30, 1954, *to* July 29, 1967, *that I last saw the deceased alive on* May 25, 1967, *and that death occurred at* 10:03a m., *from the causes and on the date stated above.*

23a. SIGNATURE R. D. Stover 507 (Degree or title)
23b. ADDRESS 939 Bryden Ave., Lewiston, Ida 83501
23c. DATE SIGNED 7/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho.

DATE REC'D BY LOCAL REG. 7-31-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar
LICENSE NO. E315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED 360 JUL 27 1967 Bureau of Vital Statistics

State File No. 3199
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Oneida
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City
LENGTH OF STAY (in this place): - 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home- 71 Evans Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Oneida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City 360
d. STREET ADDRESS (If rural, give location): 71 Evans Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	WILLIAM	ALBERT	TUBBS	July	15	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	widowed 2	Nov. 13, 1879	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: -
11. BIRTHPLACE (State or foreign country): Farmington, Davis, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: DANIEL TUBBS — BIRTHPLACE: BERKSHIRE, ENGLAND
14. MOTHER'S MAIDEN NAME: FRANCES ANNE STUART — BIRTHPLACE: Dedford Kent, Englar

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: 519-60-4636-J1y
17. INFORMANT'S OWN SIGNATURE: Earl G. Tubbs — ADDRESS: Rt 1 Malad Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Found dead at home - appro
36 hours —
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Deceased has Medical History OF heart trouble

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
None		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Found dead at home	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 15, 19 67 *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred* July 15 67, *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Raiford G. Benson 583	4 Coroner	132 W 3 N..Malad, Idaho	July 17, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 17, 1967	Malad City Cemetery	Malad City Oneida Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 17, 1967	Ruth G Sweeten	Raiford G. Benson	E-351

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 17 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 23 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

AUG 29 1967

AUG 30 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

SEP 19 1967

(a) Knowingly supply false information to any one connected with completing a death certificate.

SEP 22 1967

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

OCT 10 1967

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED.

DEC 11 1967

(d) Alter a certificate on file in the office of a local registrar.

FEB 7 1978

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3200
Local Reg. No. 41
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Payette 380	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Unknown 00 b. COUNTY: Unknow
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rt 5 Caldwell 000	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 000: Unknown
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 9 Miles S.E. New Plymouth	d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)	a. (First): Dave	b. (Middle) 000: NMN	c. (Last): Burns	4. DATE OF DEATH (Month) (Day) (Year): Unknown
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4	8. DATE OF BIRTH: Oct 23 1915	9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lobor 04	10b. KIND OF BUSINESS OR INDUSTRY: Farm	11. BIRTHPLACE (State or foreign country): Mont 7	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Unknown	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes	(If yes, give war or dates of service): World War 24	16. SOCIAL SECURITY NO.: 558-26-3391	17. INFORMANT'S OWN SIGNATURE: Donald F Brown	ADDRESS: Veterans Adm. Records. Grand Jct. Colo

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9299

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drownding — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES XX NO ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify): Unknown	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I* ~~attended the deceased from~~ Investigated X July 1, 19 67, ~~that I last saw the deceased alive on~~ ~~19~~ ~~and that death occurred at~~ Unknown, *from the causes and on the date stated above.*

23a. SIGNATURE: Hardy H Jackson 583	(Degree or title): Cornor 4	23b. ADDRESS: 112½ N 8th Payette, Ida	23c. DATE SIGNED: 7/8/67
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 7/11/67	24c. NAME OF CEMETERY OR CREMATORY: Rosedale Mem. Gardens	24d. LOCATION (City, town, or county) (State): Payette Idaho
DATE REC'D BY LOCAL REG.: July 10-1967	REGISTRAR'S SIGNATURE: Roberta E Shaffer	25. EMBALMER: Donald F Brown	LICENSE NO.: E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3201
Local Reg. No. 44
Reg. Dist. No. 330

BIRTH NO.

RECEIVED JUL 24 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 380 Payette 108

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette

c. LENGTH OF STAY in this place: 8 yrs.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1648 Center Ave. 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 380 b. COUNTY Payette

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette

d. STREET ADDRESS (If rural, give location) 1648 Center Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	VERNON	(NMN)	HILL	July 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married 3	April 22, 1888	79	-- / --	- / -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Millworker 17	Lumber	Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elby Hill	Indiana	Melissa (Unknown)	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - -	518-03-3188	Clayton J. Hill	Spokane, Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

001X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Silico-tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - - - - - -	- - - - - - - - - - - - - - - - - - - -	- -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
- - - - - - - - m.		- -

22. *I hereby certify that I attended the deceased from* June 14, 1967, *to* July 17, 1967, *that I last saw the deceased alive on* July 11, 1967, *and that death occurred at* 10:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. E. Leonard 082	M.D.	Payette Idaho	7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 21, 1967	Riverside Cemetery	Payette, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-21-67	Roberta E. Shaffer	Gifford K. Shaffer	E-344

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

FEB 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3202
Local Reg. No. 43
Reg. Dist. No. 330

RECEIVED
JUL 24 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 40 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanatarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 3rd Avenue South

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle) Matilda
c. (Last) Coulter

4. DATE OF DEATH (Month) (Day) (Year) July 17, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH April 16, 1882
9. AGE (In years last birthday) 85 Yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Bethel, Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Cochran BIRTHPLACE Maine
14. MOTHER'S MAIDEN NAME Louise Schaeffer BIRTHPLACE Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Ralph F. Larson ADDRESS Pocatello, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardiovascular Disease with Thrombosis (Coronary) — INTERVAL BETWEEN ONSET AND DEATH 20 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 6, 1967 *to* July 17, 1967, *that I last saw the deceased alive on* June 28, 1967, *and that death occurred at* 9:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE E. G. Carroll, M.D. 082 (Degree or title)
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED 7-17-1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-20-1967
24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery
24d. LOCATION (City, town, or county) Payette, Idaho (State)

DATE REC'D BY LOCAL REG. 7-20-1967
REGISTRAR'S SIGNATURE Roberta E. Shaffer
25. EMBALMER Gifford R. Shaffer LICENSE NO. E-344

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shaffer Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3203
Local Reg. No. 45
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
LENGTH OF STAY (in this place) 10 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) Bancroft Hotel

3. NAME OF DECEASED (Type or Print)
a. (First) Emma
b. (Middle) A.
c. (Last) Clancy

4. DATE OF DEATH (Month) (Day) (Year) July 29 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH Sept 8 1885

9. AGE (In years last birthday) 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 11

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-60-6219

17. INFORMANT'S OWN SIGNATURE Donald F Brown ADDRESS Idaho Public Assistance Payette, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

260X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive cardiovascular disease — ~~Hours~~
DUE TO (c) Diabetes and obesity — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-25-67, 19___, *to* 7-29-67, 19___, *that I last saw the deceased alive on* 7-27-67, 19___, *and that death occurred at* 4:40p m., *from the causes and on the date stated above.*

23a. SIGNATURE 574 (Degree or title) M.D.

23b. ADDRESS 16 S. 9th Payette, Idah

23c. DATE SIGNED 8/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/2/67

24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery

24d. LOCATION (City, town, or county) Payette, Idaho (State)

DATE REC'D BY LOCAL REG. 8-2-1967

REGISTRAR'S SIGNATURE Roberta E Shaffer

25. EMBALMER Donald F Brown

LICENSE NO. E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3204
Local Reg. No. 2
Reg. Dist. No. 500-602

RECEIV

Certificate of Death

STATE OF IDAHO

BIRTH NO.

JUL 21 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Power 390 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place): 6 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): EDITH
b. (Middle): COMINNOTTI
c. (Last): RAMEY

4. DATE OF DEATH (Month) (Day) (Year): July 14, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 24, 1912
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months 4, Days 20 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Clayton, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Antone Cominnotti — BIRTHPLACE: Italy
14. MOTHER'S MAIDEN NAME: Giovanni Pedrni — BIRTHPLACE: Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-44-1027
17. INFORMANT'S OWN SIGNATURE: W. H. Ramey — ADDRESS: Aberdeen, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

464X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-27-, 1963, *to* 7-14-, 1967, *that I last saw the deceased alive on* 7-14-67, 19__, *and that death occurred at* 12:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 141 MD 1
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Burial 3
24b. DATE: 7-17-67
24c. NAME OF CEMETERY OR CREMATORY: Aberdeen Cemetery
24d. LOCATION (City, town, or county) (State): Aberdeen Idaho

DATE REC'D BY LOCAL REG.: 7-19-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Bud Kelly — LICENSE NO.: E-467

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED JUL 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3205
Local Reg. No. 3
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 390 Power
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060
b. COUNTY Bingham 303
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ALBERT	HENRY	WALKER	July 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	July 27, 1887	79	11	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Union, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert I. Walker	Utah	Harriet C. Sharp	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-01-1095	Annie L. Walker	Aberdeen, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute coronary acclusion with block.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-14-67, 19__, *to* 7-14, 1967, *that I last saw the deceased alive on* 7-14-, 1967, *and that death occurred at* 7 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	American Falls, Idaho	7-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	7-18-67	Aberdeen Cemetery	Aberdeen, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-67	[signature]	H. L. Davis	H. L. Davis E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3206
Local Reg. No. 5
Reg. Dist. No. 560-602

RECEIVED JUL 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 390 Power 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls, Idaho
LENGTH OF STAY (in this place) 2days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 03 Arizona b. COUNTY 555 Maricopa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Phoenix
d. STREET ADDRESS (If rural, give location) 1034 W. McKinley

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALBERT	M.	DALTON	July 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months	Days	If UNDER 24 HRS.: Hours	Min.
Male	White	Unknown 0	Jan 27, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 10	S.P. R. R.	Malad, Idaho	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
A. A. Dalton	Utah	Margaret Roberts	Malad, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		567-01-8903A	Catherine Stallings	Eden, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Congestive Failure 2°

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Infarction

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 2days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-18- , 1967, *to* 7-20- , 1967, *that I last saw the deceased alive on* 7-20- , 1967, *and that death occurred at* 6:20 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dalton MD	American Falls, Idaho	7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	7-20-67	Tremonton Cemetery	Tremonton, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-25-67	Callen Hadfield	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JUL 28 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3207
Local Reg. No. 4
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 390 Power
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 5 mi. NW American Falls 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ARNOLD	ERNEST	POULSON	July 20 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 30, 1913	53	7	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Sandy, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ole Andrew Poulson	Sweden	Anna Nilsson	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-42-9980	Doris Poulson	Am. Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH Instantaneous Instant.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-18- , 1962, *to* 7-20- , 1967, *that I last saw the deceased alive on* 3-7- , 1967, *and that death occurred at* 2 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
141 MD	American Falls, Idaho	7-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-22-67	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-25-67	Callen Hadfield	H. L. Davis	E-253

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3208
Local Reg. No. 6
Reg. Dist. No. 501-602

Certificate of Death

STATE OF IDAHO

RECEIVED
JUL 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 390 Power 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rockland
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home (Rockland Cafe) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rockland
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) VIRGIL
b. (Middle) W.
c. (Last) SCHMETT

4. DATE OF DEATH (Month) July (Day) 22, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 3, 1914
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months 10, Days 19 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman 10
10b. KIND OF BUSINESS OR INDUSTRY: U. P. Railroad
11. BIRTHPLACE (State or foreign country): Lynnville, Indiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Schmett — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Anna Kress — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-34-0194
17. INFORMANT'S OWN SIGNATURE: June Schmett — ADDRESS: Rockland, Idaho

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I [illegible] that I last saw the deceased dead on* July 22, 19 67, *and that death occurred at* 4:30a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Bud Kelly — 583 (Degree or title) Coroner 4
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 7-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Burial 3
24b. DATE: 7-25-67
24c. NAME OF CEMETERY OR CREMATORY: Valley View Cemetery
24d. LOCATION (City, town, or county) (State): Rockland, Idaho

DATE REC'D BY LOCAL REG.: 7-25-67
REGISTRAR'S SIGNATURE: Callum Goodfield
25. EMBALMER: H. L. Davis — LICENSE NO. E-253

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3209
Local Reg. No. 46
Reg. Dist. No. 140

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 402 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Evelyina c. (Last) Owen

4. DATE OF DEATH (Month) (Day) (Year) July 3, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 10-9-1880
9. AGE (In years last birthday) 86 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Madison County, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME deceased BIRTHPLACE
14. MOTHER'S MAIDEN NAME deceased BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 479-10-8937
17. INFORMANT'S OWN SIGNATURE R L Owen ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, hypostatic — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cachexia — Months
DUE TO (c) Diabetes + arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 28 June, 1967, *to* 3 July, 1967, *that I last saw the deceased alive on* 2 July, 1967, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE William Nolan 672 (Degree or title) MD
23b. ADDRESS Wallace
23c. DATE SIGNED 3 July 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-7-67
24c. NAME OF CEMETERY OR CREMATORY Ames Municipal
24d. LOCATION (City, town, or county) Ames, Iowa (State)

DATE REC'D BY LOCAL REG. 7-5-67
REGISTRAR'S SIGNATURE Dale L Cornell
25. EMBALMER Dale L. Cornell
LICENSE NO. E 406

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3210
Local Reg. No.
Reg. Dist. No.

RECEIVED
JUL 12 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 315
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
LENGTH OF STAY (in this place) 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 401 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) Box 502

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) H. c. (Last) Howard
4. DATE OF DEATH (Month) July (Day) 3, (Year) 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH April 21, 1886
9. AGE (In years last birthday) 81 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Forest Ranger
10b. KIND OF BUSINESS OR INDUSTRY 08 Forestry
11. BIRTHPLACE (State or foreign country) St Paul, Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME George Howard BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Annie Phillipson BIRTHPLACE Minnesota
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-10-8601
17. INFORMANT'S OWN SIGNATURE Charles Rodgers ADDRESS 2040

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphocytic Leukemia — INTERVAL BETWEEN ONSET AND DEATH 1 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 6-17-67, 19__, to 7-3-67, 19__, that I last saw the deceased alive on 6-27-67, 19__, and that death occurred at 4:05 A.m., from the causes and on the date stated above.

23a. SIGNATURE [signature] 052 (Degree or title)
23b. ADDRESS 240 Kellogg Idaho
23c. DATE SIGNED 7-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg (State) Idaho

DATE REC'D BY LOCAL REG. 7/10-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Ronald Maisel LICENSE NO. 456
FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3211
Local Reg. No.
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG - 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
c. LENGTH OF STAY (in this place) 33 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home at 508 5th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
d. STREET ADDRESS (If rural, give location) 508 5th Street

3. NAME OF DECEASED (Type or Print)
a. (First) Melvin
b. (Middle) 000
c. (Last) Harrington

4. DATE OF DEATH (Month) (Day) (Year) July 4, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH May 31, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 1 Days 3 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Kellogg, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Janet Gregory
BIRTHPLACE Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Janet M Harrington
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Unexpected Sudden Death of Infancy — INTERVAL BETWEEN ONSET AND DEATH unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from —, 19—, to —, 19—, that I last saw the deceased alive on —, 19—, and that death occurred at 10:30 A m., from the causes and on the date stated above.*

23a. SIGNATURE William N Dice 672 (Degree or title) M.D.
23b. ADDRESS Wallace
23c. DATE SIGNED 25 Jul 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Shoshone Mem. Gdns.
24d. LOCATION (City, town, or county) Pinehurst (State) Idaho

DATE REC'D BY LOCAL REG. 7-27-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Donald Maisel
LICENSE NO. 452

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: D-67-4867

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3212
Local Reg. No.
Reg. Dist. No.

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 12 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 404
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (In this place) 4 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 401 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 306 East Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) Martha
b. (Middle) A. 141
c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) July 4, 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 3, 1890
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Fond du Lac, Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME William Voigtlander — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Minnie Storrck — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-62-4186
17. INFORMANT'S OWN SIGNATURE Wm. F. Smith — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes mellitus — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Myocardial insufficiency — 1 day

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 30, 1967, *to* July 4, 1967, *that I last saw the deceased alive on* July 4, 1967, *and that death occurred at* 4:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE Orland B. Scott 461 (Degree or title) MD
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED 7/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Entombment
24b. DATE July 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Riverside Mausoleum
24d. LOCATION (City, town, or county) (State) Spokane, Wash.

DATE REC'D BY LOCAL REG. 7-10-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Donald Maisel
LICENSE NO. E452

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3213
Local Reg. No.
Reg. Dist. No.

RECEIVED JUL 12 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 262
b. CITY OR TOWN Kellogg
c. LENGTH OF STAY (in hospital) 56 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
d. STREET ADDRESS (If rural, give location) Box 535

3. NAME OF DECEASED (Type or Print) a. (First) Celest b. (Middle) M c. (Last) Bottinelli

4. DATE OF DEATH (Month) (Day) (Year) July 5, 1967

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH May 24, 1896

9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Electrician 09

10b. KIND OF BUSINESS OR INDUSTRY Electric

11. BIRTHPLACE (State or foreign country) Kellogg, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Celest Bottinelli BIRTHPLACE Italy

14. MOTHER'S MAIDEN NAME Louisa VergoBBi BIRTHPLACE Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-01-7525

17. INFORMANT'S OWN SIGNATURE Frank A. Bottinelli ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Biliary Obstruction, Intra Hepatic, Cause undet. — INTERVAL BETWEEN ONSET AND DEATH: 8 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arterio Sclerotic Heart Disease — 5 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kellogg Shoshone Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept, 1958 to 5 July, 1967, that I last saw the deceased alive on 4 July, 1967, and that death occurred at 3:35A m., from the causes and on the date stated above.

23a. SIGNATURE Glen M. Whelchel 539 (Degree or title) MD
23b. ADDRESS Kellogg, Idaho
23c. DATE SIGNED 6 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 7, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) (State) Kellogg, Idaho

DATE REC'D BY LOCAL REG. 7-10-67
REGISTRAR'S SIGNATURE Joe Lund
25. EMBALMER Donald Hand LICENSE NO. 452
FIRM NAME: Morgal Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3214
Local Reg. No.
Reg. Dist. No.

RECEIVED JUL 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (In this place) 10 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 407
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 215 Elder

3. NAME OF DECEASED (Type or Print) a. (First) Melton b. (Middle) Henry 241 c. (Last) Amos

4. DATE OF DEATH (Month) July (Day) 6, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Nov. 7, 1909

9. AGE (In years last birthday) 57 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN 07

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Oklahoma

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William G. Amos — BIRTHPLACE Oklahoma

14. MOTHER'S MAIDEN NAME Bessie Floss — BIRTHPLACE Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-07-9787

17. INFORMANT'S OWN SIGNATURE Mrs Violet Amos — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, intra thoracic — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute thoracic injury — 9 hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) At work - mine

21c. (CITY, TOWN, OR TOWNSHIP) Kellogg 13 (COUNTY) 401 Shoshone (STATE) Idaho

21d. TIME OF INJURY (Month) July (Day) 6 (Year) 1967 (Hour) about 10 a.m. p.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Fell

22. *I hereby certify that I attended the deceased from* 7/6, 1967, *to* 7/6, 1967 *that I last saw the deceased alive on* 7/6, 1967, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 461 (Degree or title) MD

23b. ADDRESS Kellogg Idaho

23c. DATE SIGNED 7/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 10, 1967

24c. NAME OF CEMETERY OR CREMATORY Greenwood

24d. LOCATION (City, town, or county) Kellogg (State) Idaho

DATE REC'D BY LOCAL REG. 7/14/67

REGISTRAR'S SIGNATURE Joe Devine

25. EMBALMER Donald Maisel — LICENSE NO. E452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 5 1974

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 14 1978

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

JAN 26 1984

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3215
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

RECEIVED
JUL 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 087 SHOSHONE
b. CITY OR TOWN KELLOGG
c. LENGTH OF STAY in this place
d. FULL NAME OF HOSPITAL OR INSTITUTION McCONNELL HOTEL 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO b. COUNTY 087 SHOSHONE
c. CITY OR TOWN KELLOGG
d. STREET ADDRESS (If rural, give location) 212 MAIN ST.

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS b. (Middle) c. (Last) LARSON

4. DATE OF DEATH (Month) (Day) (Year) July 7 1967

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2
8. DATE OF BIRTH MAY 1, 1885
9. AGE (In years last birthday) 82 If under 1 year: Months Days If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED PAINTER 07
10b. KIND OF BUSINESS OR INDUSTRY MINING
11. BIRTHPLACE (State or foreign country) NORWAY
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME UNKNOWN BIRTHPLACE UNKNOWN
14. MOTHER'S MAIDEN NAME UNKNOWN BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) NONE
16. SOCIAL SECURITY NO. 518-05-3134
17. INFORMANT'S OWN SIGNATURE Emma Larson ADDRESS 4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis — unk.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 4 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE William Davis M.D. (Degree or title)
23b. ADDRESS Wallace
23c. DATE SIGNED 12 Jul. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE July 11, 1967
24c. NAME OF CEMETERY OR CREMATORY GREENWOOD
24d. LOCATION (City, town, or county) KELLOGG, (State) IDAHO

DATE REC'D BY LOCAL REG. 7/14/67
REGISTRAR'S SIGNATURE Joe Irvine
25. EMBALMER Robert H. Rose
LICENSE NO. E-497
FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 36-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3216
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

JUL 24 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 487 b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 900 So. Div.

3. NAME OF DECEASED (Type or Print) a. (First) Lillian b. (Middle) A. 141 c. (Last) Ewing

4. DATE OF DEATH (Month) (Day) (Year) July 15, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2

8. DATE OF BIRTH May 17, 1895

9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Inn Keeper 93

10b. KIND OF BUSINESS OR INDUSTRY Restaurant

11. BIRTHPLACE (State or foreign country) Bonner, Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Elie Hussa | BIRTHPLACE Finland

14. MOTHER'S MAIDEN NAME Anna Hussa | BIRTHPLACE Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 519-18-2298

17. INFORMANT'S OWN SIGNATURE George B. Ostman | ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 8 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Dec 20 1966

19b. MAJOR FINDINGS OF OPERATION Carcinoma of stomach.

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 13, 1966, *to* July 15, 1967, *that I last saw the deceased alive on* July 15, 1967, *and that death occurred at* 9:05 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Orland B. Scott 461 (Degree or title)

23b. ADDRESS Kellogg Idaho

23c. DATE SIGNED 7/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 19, 1967

24c. NAME OF CEMETERY OR CREMATORY Greenwood

24d. LOCATION (City, town, or county) (State) Kellogg, Idaho

DATE REC'D BY LOCAL REG. 7/20/67

REGISTRAR'S SIGNATURE

25. EMBALMER Donald Masel E452 | LICENSE NO.

FIRM NAME: Masel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG - 1 1967 Bureau

Certificate of Death

STATE OF IDAHO

State File No. 3217
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 401 Shoshone 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 401 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 830 So. Div.

3. NAME OF DECEASED (Type or Print)
a. (First): Chester
b. (Middle): Arthur 141
c. (Last): Schram

4. DATE OF DEATH (Month) (Day) (Year): July 20, 1967

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 9, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Grocer
10b. KIND OF BUSINESS OR INDUSTRY: 22 Grocery
11. BIRTHPLACE (State or foreign country): Wabasha, Minn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mathis Schram — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Anna Lundlanger — BIRTHPLACE: Luxemburg

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-10-9579
17. INFORMANT'S OWN SIGNATURE: Arthur E Schram — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic Heart — 10 years
DUE TO (c): Brain disease

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Chronic cystitis, Prostatitis — 2 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kellogg Shoshone Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 Feb, 1967 *to* July 20, 1967, *that I last saw the deceased alive on* July 20, 1967 *and that death occurred at* 8:58 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Glen M. Colwell 539 (Degree or title) MD
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 26 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: July 24, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 7-27-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Donald Maisel — LICENSE NO. 452
FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

AUG 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 27 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 11 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES; Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3218
Local Reg. No.
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG - 1 1967

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg Bureau
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555 King
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Seattle
d. STREET ADDRESS (If rural, give location) 8319 46th So. West

3. NAME OF DECEASED (Type or Print)
a. (First) Ruth
b. (Middle) R. S. 741
c. (Last) Warren

4. DATE OF DEATH (Month) (Day) (Year) July 24, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH July 3, 1883
9. AGE (In years last birthday) 84 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY Education
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George C. Shutts — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Emma Ludden — BIRTHPLACE Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None 4209
16. SOCIAL SECURITY NO. 532-24-3426
17. INFORMANT'S OWN SIGNATURE Mrs Rupert Rex — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. As above.

INTERVAL BETWEEN ONSET AND DEATH: Years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-20, 1967, *to* 7-24, 1967, *that I last saw the deceased alive on* 7-23, 1967, *and that death occurred at* 9:40 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Ronald K. Poole MD 765 (Degree or title)
23b. ADDRESS 204 Oregon St. Kellogg
23c. DATE SIGNED 7-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2
24b. DATE July 27, 1967
24c. NAME OF CEMETERY OR CREMATORY Hazen & Jaeger
24d. LOCATION (City, town, or county) (State) Spokane, Wash.

DATE REC'D BY LOCAL REG. 7-27-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Donald Maisel — LICENSE NO. E452
FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 1967

FEB 20 1986

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3219
Local Reg. No. 48
Reg. Dist. No. 140

BIRTH NO.

RECEIVED AUG - 4 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 402 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 403 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location) Weir Gulch

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle) Arthur
c. (Last) Shannon

4. DATE OF DEATH (Month) (Day) (Year) July 24, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH 1-10-1901

9. AGE (In years last birthday) 66
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) N. P. Railroad 10

10b. KIND OF BUSINESS OR INDUSTRY Car Repair

11. BIRTHPLACE (State or foreign country) Wallace, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Shannon
BIRTHPLACE Canada

14. MOTHER'S MAIDEN NAME Margaret Burns
BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 701-14-0034

17. INFORMANT'S OWN SIGNATURE Mrs. J. E. Scott
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage
INTERVAL BETWEEN ONSET AND DEATH: 62 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardiovascular Renal Disease
Several years
DUE TO (c) Uremia Myocardial Infarction
about 10 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-12, 1967, *to* 7-24, 1967, *that I last saw the deceased alive on* 7-24, 1967, *and that death occurred at* 11:43 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE A. M. Peterson, M.D. (Degree or title)

23b. ADDRESS Wallace, Idaho

23c. DATE SIGNED 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 26-67

24c. NAME OF CEMETERY OR CREMATORY Nine Mile

24d. LOCATION (City, town, or county) (State) Wallace, Idaho

DATE REC'D BY LOCAL REG. 8-1-67

REGISTRAR'S SIGNATURE Dale Cornell

25. EMBALMER Dale L. Cornell

LICENSE NO. E 406

FIRM NAME: Cornell's-Ward Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3220
Local Reg. No. 47
Reg. Dist. No. 140

BIRTH NO.

AUG - 4 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY (40) Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho (40B)
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Joseph
b. (Middle) Dale (141)
c. (Last) Babin

4. DATE OF DEATH (Month) July (Day) 25, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 2-19-

9. AGE (In years last birthday) 75
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired (07)

10b. KIND OF BUSINESS OR INDUSTRY Mining & Elec.

11. BIRTHPLACE (State or foreign country) Cloquet, Minn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Babin
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Amelia Iancourt
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 533-12-9537

17. INFORMANT'S OWN SIGNATURE Floyd D. Babin
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Penis (1799)
INTERVAL BETWEEN ONSET AND DEATH: 6-8 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 8, 1967, *to* July 25, 1967, *that I last saw the deceased alive on* July 25, 1967, *and that death occurred at* 4:38A m., *from the causes and on the date stated above.*

23a. SIGNATURE Orland Brott MD (461) (Degree or title)

23b. ADDRESS Kellogg Idaho

23c. DATE SIGNED 8/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 28-67

24c. NAME OF CEMETERY OR CREMATORY Nine Mile

24d. LOCATION (City, town, or county) Wallace, Idaho (State)

DATE REC'D BY LOCAL REG. 8-29-67

REGISTRAR'S SIGNATURE Dale Cornell

25. EMBALMER Dale L. Cornell

LICENSE NO. E-406

FIRM NAME Cornell-Ward

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3221
Local Reg. No. 62
Reg. Dist. No. 142

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 404
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 3½ hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280 ~~400~~
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cataldo
d. STREET ADDRESS (If rural, give location) Cataldo, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) Larry
b. (Middle) L. 141
c. (Last) Beare

4. DATE OF DEATH (Month) (Day) (Year) July 25, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH June 27, 1950
9. AGE (In years last birthday) 17 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY Student
11. BIRTHPLACE (State or foreign country) Wallace, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ben Beare — BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Grace Self — BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-62-4361
17. INFORMANT'S OWN SIGNATURE Ben H Beare — ADDRESS Cataldo, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Massive Brain Damage — INTERVAL BETWEEN ONSET AND DEATH 2 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pelvic fractures, left radius, Amp. fract. left Achilles, Endofin separation — 2 hours

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 26
21c. (CITY, TOWN, OR TOWNSHIP) Kellogg 13 — (COUNTY) Shoshone 401 — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 25 67 1:45 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car wreck

22. *I hereby certify that I attended the deceased from* 25 July, 1967 *to* 25 July, 1967, *that I last saw the deceased alive on* 25 July, 1967, *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Glen M. Whitesel 539 (Degree or title) MD
23b. ADDRESS Kellogg, Idaho
23c. DATE SIGNED 27 July 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 29, 1967
24c. NAME OF CEMETERY OR CREMATORY Forest
24d. LOCATION (City, town, or county) Coeur D'Alene — (State) Idaho

DATE REC'D BY LOCAL REG. 8/8/67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Donald Maisel — LICENSE NO. E452

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAR 6 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3222
Local Reg. No. 63
Reg. Dist. No. 142

Certificate of Death

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place) 6 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) County Nursing Home 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 401
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 111 Presley Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) ELIZABETH
b. (Middle)
c. (Last) WARNER

4. DATE OF DEATH (Month) July (Day) 26, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 9, 1867
9. AGE (In years last birthday) 100 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Misouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John A. Good — BIRTHPLACE Switzerland
14. MOTHER'S MAIDEN NAME Barbara Baumberger — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Floyd L. Warner — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cassive Congestion I

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Vascular Nerons I
DUE TO (c) Myocardial weakness

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1940, 19__, *to* 4-9, 1967, *that I last saw the deceased alive on* 7-1, 1967, *and that death occurred at* 4 *m., from the causes and on the date stated above.*

23a. SIGNATURE Robert Stating 494 (Degree or title) 1
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 28, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg, (State) Idaho

DATE REC'D BY LOCAL REG. 8/8/67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Robert G. Ross
LICENSE NO. E-497

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: MAISEL FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3223
Local Reg. No. 64
Reg. Dist. No. 142

Certificate of Death

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place) 6 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone Nursing Home 323 ~~138~~

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 401
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) Kellogg, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle)
c. (Last) Kenyon

4. DATE OF DEATH (Month) (Day) (Year) July 29, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH Oct. 7, 1873
9. AGE (In years last birthday) 93 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired teacher
10b. KIND OF BUSINESS OR INDUSTRY 2 Education
11. BIRTHPLACE (State or foreign country) Rose Hill, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-60-9949 J1
17. INFORMANT'S OWN SIGNATURE Madge Turner — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5705

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH 9 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) abdominal adhesions
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arteriosclerosis

19a. DATE OF OPERATION 5/25/67
19b. MAJOR FINDINGS OF OPERATION Intestinal obstruction
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 19, 1957, *to* July 29, 1967, *that I last saw the deceased alive on* July 29, 1967 *and that death occurred at* 4:40A *m., from the causes and on the date stated above.*

23a. SIGNATURE Orland B. Scott M.D. 461 (Degree or title)
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED 8/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg, Idaho (State)

DATE REC'D BY LOCAL REG. 8/8/67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Donald Maisel — LICENSE NO. E452

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3224
Local Reg. No. 12-23
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 11 1967 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
a. COUNTY 431 Twin Falls 304
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (In this place) 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION Twin Falls Clinic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 428
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) R.F.D. # 3

3. NAME OF DECEASED (Type or Print) a. (First) CARL b. (Middle) WENTWORTH c. (Last) BEAMS

4. DATE OF DEATH (Month) (Day) (Year) July 1, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 28, 1900
9. AGE (In years last birthday) 67 — If UNDER 1 YEAR Months / Days — If UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Superintendent of Highway District
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) New York
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harvey Beams — BIRTHPLACE No Record
14. MOTHER'S MAIDEN NAME Hattie Hunt — BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-03-0592
17. INFORMANT'S OWN SIGNATURE Tommy L Beams ADDRESS Twin Falls Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart dis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Previous coronary occlusion.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 27, 1961, *to* July 1, 1967, *that I last saw the deceased alive on* June 23, 1967, *and that death occurred at* 5:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title) MD
23b. ADDRESS 122 9th Ave No Buhl
23c. DATE SIGNED 7-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/5/67
24c. NAME OF CEMETERY OR CREMATORY Buhl
24d. LOCATION (City, town, or county) Buhl, (State) Idaho

DATE REC'D BY LOCAL REG. 7-6-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER Robert F. Dickard
LICENSE NO. E-312

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3225
Local Reg. No. D-548
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 13 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY IN THIS PLACE 8 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka
c. CITY OR TOWN Rupert

d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Memorial Hosp
d. STREET ADDRESS (If rural, give location): 816 7th street

3. NAME OF DECEASED (Type or Print): a. (First) GIOVANNA b. (Middle) 143 c. (Last) FIORENTINI

4. DATE OF DEATH: (Month) July (Day) 2 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	Feb 4 1896	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired housewife	01	Roncegno-Cadenzi-Italy	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
not available	Not available	not available	not available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	519-44-9860	Amelia M. Henscheid	Rte. 1 Rupert

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinomatosis - abdomen
DUE TO (c) Carcinoma, ovary

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Carcinomatosis abdomen	YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* 7/2, 1967, *and that death occurred at* A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
George W. Warner MD 551 (Degree or title)	1116 5th Ave E Twin Falls	7/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	7-2-1967	Paul Cemetery	Paul Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-12-67	Pamela J. Johnson	Robert O Walk	E 294

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 19 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 27 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3226
Local Reg. No. 0-238
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 11 1967 BUREAU OF VITAL STATISTICS

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place) 31 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Addison Ave. East (Rte 3)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42 Twin Falls
c. CITY OR TOWN Twin Falls
d. STREET ADDRESS (If rural, give location) Addison Avenue East (Rte 3)

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) LEE c. (Last) MORRIS

4. DATE OF DEATH (Month) (Day) (Year) July 2, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 10, 1896
9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Randall, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph E. Morris BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Ellen Easter BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-40-9831
17. INFORMANT'S OWN SIGNATURE Mrs C. L. Morris ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH 1 HR.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) HYPERTENSIVE CARDIOVASCULAR RENAL DISEASE — 1 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. HYPERCHOLESTEROLEMIA — 1 yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1948, 19___, *to* 7-2-67, 19___, *that I last saw the deceased alive on* 7-2-67, 19___, *and that death occurred at* 9:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Joseph W. Marshall. MD (330) (Degree or title)
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 7-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 7-6-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER William J. Boyd
LICENSE NO. E-490

FIRM NAME: Twin Falls Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 12 1967

APR 18 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended July 21, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3227
Local Reg. No. D-241
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 32 / Twin Falls 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) WKS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazeldel Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 320
b. COUNTY Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Jane b. (Middle) S. 285 c. (Last) Carothers

4. DATE OF DEATH (Month) July (Day) 4, (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Aug. 3, 1892

9. AGE (In years last birthday) 74 | IF UNDER 1 YEAR Months 11 Days 1 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Granite County, Montana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank Carnegie BIRTHPLACE Minn.

14. MOTHER'S MAIDEN NAME Sara Schmidt BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 518-32-6565

17. INFORMANT'S OWN SIGNATURE Frank N. Carothers ADDRESS Shoshone, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

33 LX

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal heart failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Embolism rt axillary artery

DUE TO (c) Cerebral Vascular Accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Epilepsy

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 19 67, *to* July 4, 19 67, *that I last saw the deceased alive on* July 4, 19 67, *and that death occurred at* A m., *from the causes and on the date stated above.*

23a. SIGNATURE R. A. Drake, M.D. 146 (Degree or title)

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 7-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-7-1967

24c. NAME OF CEMETERY OR CREMATORY Shoshone Cemetery

24d. LOCATION (City, town, or county) (State) Shoshone, Idaho

DATE REC'D BY LOCAL REG. 7-10-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Frances M. Bergin

LICENSE NO. E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED JUL 20 1967 Bureau of Vital Statistics

State of Idaho } ss.
County of Lincoln }

Certificate No.

Date Filed July 13, 1967

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)

for Jane S. Carothers (Name on Original Certificate) who died (Was Born or Died) on July 4, 1967 (Date of Event)

in Twin Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 11	Phillipsburg, Granit County, Montana	Granite County, Montana

Subscribed and sworn to before me this 19th day of July 1967

Darrell A. Thorne

Notary Public, residing at Shoshone, Idaho

My commission expires April 9, 1969

(Seal)

X Signed Frances M. Bergin

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Box 546 — SHOSHONE, IDA

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Lincoln }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 19th day of July 1967

Darrell A. Thorne

Notary Public, residing at Shoshone, Idaho

My commission expires April 9, 1969

(Seal)

X Signed Ida B Stickney

(Signature of Any Credible Person)

SHOSHONE IDA

(Street Address, City, State)

FORM DH 60-155

[illegible]

[illegible]

Affidavit to Correct or Amend for Delayed Certificate of Birth or Death

State of [illegible] ss. Certificate No.

County of [illegible] Date [illegible] July 13, 1967

The undersigned [illegible] death

[illegible] Jane S. Carothers died July 4, 1967

[illegible] Twin Falls, Idaho [illegible]

[illegible]

Item 11 Phillipsburg, Granit County, Montana Granite County, Montana

[illegible]

[illegible]

[illegible]

[illegible]

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State [illegible] ss.

County of [illegible]

[illegible]

[illegible]

Signed [illegible]

Notary Public [illegible]

My commission [illegible]

[illegible]

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
JUL 13 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. D-241
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
STAY (in this place): Wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazeldel Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JANE
b. (Middle): S.
c. (Last): CAROTHERS

4. DATE OF DEATH (Month) (Day) (Year): July 4, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: Aug. 3, 1892
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months 11, Days 1 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Granite county Phillipsburg, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Carnegie — BIRTHPLACE: Minn.
14. MOTHER'S MAIDEN NAME: Sara Schmidt — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 518-32-6565
17. INFORMANT'S OWN SIGNATURE: X Frank Carothers — ADDRESS: Shoshone, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Terminal heart failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Embolism Rt Apiley
DUE TO (c): Cerebral vascular accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Injuring

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* July 4, 1967, *that I last saw the deceased alive on* July 4, 1967, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R A Drake M.D.
23b. ADDRESS: Twin Falls Idaho
23c. DATE SIGNED: 7-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7-7-1967
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 7-10-67
REGISTRAR'S SIGNATURE: Pamela J Johnson
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 21 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3228
Local Reg. No. P-342
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JUL 13 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 421 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 344 2nd Ave West

3. NAME OF DECEASED (Type or Print)
a. (First) JUNE
b. (Middle) Marjorie
c. (Last) McCormack

4. DATE OF DEATH (Month) (Day) (Year) July 5, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH June 10, 1919
9. AGE (In years last birthday) 48 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Eden, Idaho
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Leonard Woodland — BIRTHPLACE Richmond, Utah
14. MOTHER'S MAIDEN NAME Ellen Lavon Walton — BIRTHPLACE Montana
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-22-3506
17. INFORMANT'S OWN SIGNATURE Mrs. Cleota Buxton — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 170X Hydrothorax — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastatic Carcinoma Breast — 3 1/2 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-28, 1965, *to* 7-5, 1967, *that I last saw the deceased alive on* 7-5, 1967; *and that death occurred at* 12.20A *m., from the causes and on the date stated above.*

23a. SIGNATURE Harry Brumbach Jr. 064 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 7.5.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7. 8. 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 7-10-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER [signature]
LICENSE NO. 343
FIRM NAME White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3229
Local Reg. No. D-240
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY TwinFalls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) Sky Manor

3. NAME OF DECEASED (Type or Print)
a. (First) GENEVIEVE
b. (Middle) R.
c. (Last) HOLLENBECK

4. DATE OF DEATH (Month) (Day) (Year) July 5, 1967

5. SEX Fe MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2
8. DATE OF BIRTH M AUGUST 28, 1884
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Palmer, Kansas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Michael D. Kern — BIRTHPLACE New York
14. MOTHER'S MAIDEN NAME Margaret A. Dolan — BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-24-2787-A
17. INFORMANT'S OWN SIGNATURE [signature] — ADDRESS [illegible]

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion
ANTECEDENT CAUSES — massive
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardio vascular
Renal disease
DUE TO (c) old age, chronic
II. OTHER SIGNIFICANT CONDITIONS — Brain syndrome
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 1965, *to* July 5, 1967, *that I last saw the deceased alive on* July 5, 1967, *and that death occurred at* 7 pm., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 146 (Degree or title) MD-1
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 7.6.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7.8.1967
24c. NAME OF CEMETERY OR CREMATORY Twin FallsCem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 7-7-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. 343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary TwinFalls, Idaho

DUTIES:

JUL 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 24 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
JUL 13 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3230
Local Reg. No. D-246
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 160
b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Declo (Rural)
d. STREET ADDRESS (If rural, give location) Star Route

3. NAME OF DECEASED (Type or Print)
a. (First) Robert
b. (Middle)
c. (Last) Cooper

4. DATE OF DEATH (Month) (Day) (Year) July 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH June 28, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 9 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ***** 02
10b. KIND OF BUSINESS OR INDUSTRY *****
11. BIRTHPLACE (State or foreign country) Burley, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lawrence K. Cooper — BIRTHPLACE Oakley, Idaho
14. MOTHER'S MAIDEN NAME Barbara Jean Robins — BIRTHPLACE Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Larry Cooper — ADDRESS Declo, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

7562

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia, bilat — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Esophageal atresia — 9 "
DUE TO (c) — 9 "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Aortic coarctation
Annular pancreas — 9 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on* 6/7, 1967, *and that death occurred at* 1:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE E. M. Myatt 576 (Degree or title) MD.
23b. ADDRESS 636 Shoshone Ave W Twin Falls, Idaho
23c. DATE SIGNED 7/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7/10/67
24c. NAME OF CEMETERY OR CREMATORY Oakley Cemetery
24d. LOCATION (City, town, or county) (State) Oakley, Idaho

DATE REC'D BY LOCAL REG. 7-12-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER J. Garth Snyder
LICENSE NO. E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: D-67-5658

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3231
Local Reg. No. D-244
Reg. Dist. No. 460

RECEIVED
JUL 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: T. Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 462 Blue Lakes Blvd.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HOMER	EDWIN	LEE	July 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	December 27, 1894	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Maintainance Wkr. 01	Bowling Alley	Clay Center, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Israel Lee	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. #1 3	521-14-4187	Mrs. Dorothy Newberry	737 2nd Ave. E. Twin Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary thrombosis	1 week
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Coronary arteriosclerosis	unknown
DUE TO (c)	Generalized arteriosclerosis	5 years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Multiple myeloma, probable	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7-3, 19 67, *to* 7/7, 19 67, *that I last saw the deceased alive on* 7/7, 19 67, *and that death occurred at* 7:30a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. H. Quick 092	M.D.	Twin Falls, Idaho	7/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/10/67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-12-67	Pamela Johnson	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3232
Local Reg. No. 0343
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JUL 13 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE South Dakota
b. COUNTY Mellette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) White River
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Alice b. (Middle) R. c. (Last) Astleford

4. DATE OF DEATH (Month) July (Day) 7, (Year) 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH Jan. 11, 1883

9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) LeMars, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Bauerly
BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME Alice Baily
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 504-38-6889-B

17. INFORMANT'S OWN SIGNATURE Sybil Astleford ADDRESS White River, South Dakota

4200

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Ventricular Arrythmia — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 15 yr +
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 5 yr +
Fracture Left hip — 10 days

19a. DATE OF OPERATION 6/28/67

19b. MAJOR FINDINGS OF OPERATION Fracture Left hip

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 28 June, 1967, *to* 7 July, 1967, *that I last saw the deceased alive on* 7 July, 1967, *and that death occurred at* 1:40 A m., *from the causes and on the date stated above.*

23a. SIGNATURE James H. Spafford, M.D. (Degree or title) 489

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 7/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3

24b. DATE 7.8.67

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) White River, South Dakota

DATE REC'D BY LOCAL REG. 7-10-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER

LICENSE NO. 343

FIRM NAME: WHITE MORTUARY Twin Falls, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 16 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3233
Local Reg. No. D-248
Reg. Dist. No. 46-0

BIRTH NO.

JUL 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42 T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 1238 6th Avenue East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ALICE	S.	WILLIAMS	July 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	May 28, 1897	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Temple, Texas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
W.A. Swinney	Mississippi	Mary F. Bigham	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	125-22-1653	Pearle S. Potts	Reno, Nevada

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Contusion — INTERVAL BETWEEN ONSET AND DEATH: 5 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) auto accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Fracture ribs, multiple Multiple Lacerations — 5 Days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
1	Hiway - 86	13 Twin Falls 42 Twin Falls Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
July 6 '67 4:20 p.m.		Auto accident

22. *I hereby certify that I attended the deceased from* 7-6, 19 67, *to* 7/10/, 19 67, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 9:30a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
George W. Warner 55 (Degree or title) M.D.	Twin Falls, Idaho	7/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/13/67	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER James C. Reynolds	LICENSE NO.
7-14-67	Pamela J. Johnson	James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 20 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

MAR 22 1971

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 24 1967 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3234
Local Reg. No. D-255
Reg. Dist. No. 40

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
LENGTH OF STAY (in this place) 6 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. View Nursing Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Murtaugh
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Claus	Christian	Clawson	July 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 1, 1876	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Spring City, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Christian R. Clawson	Greis, Denmark	Christiane M. Larsen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-36-6920	Hattie Clawson	Murtaugh, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

455 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) General Debility — 2 yrs.
DUE TO (c) Gangrene (wet) left foot & leg — 2 mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June *19*67*, to* July 12*, 19*67*, that I last saw the deceased alive on* July 12*, 19*67*, and that death occurred at* 5:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
T. Ellis Knight MD	Kimberly, Idaho	7-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/15/67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-21-67	Pamela J. Johnson	Justin Payne	E 389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-6302.1

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3435
Local Reg. No. D-257
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED
JUL 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 / TWIN FALLS
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TWIN FALLS
STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MAGIC VALLEY MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 42 / TWIN FALLS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TWIN FALLS
d. STREET ADDRESS (If rural, give location) ROUTE #3

3. NAME OF DECEASED (Type or Print)
a. (First) REA
b. (Middle) C.
c. (Last) JAMES

4. DATE OF DEATH (Month) (Day) (Year) JULY 13th, 1967

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED
8. DATE OF BIRTH APRIL 23, 1912
9. AGE (In years last birthday) 55
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Nyssa, Oregon
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME C.C.Callen
BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Lyda Walters
BIRTHPLACE ARKANSAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-62-4669
17. INFORMANT'S OWN SIGNATURE x Jerry C. James
ADDRESS Jerome, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Small bowel Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 19hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Intra abdominal adhesions — 5 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 27 Dec, 1966, *to* 13 July, 1967, *that I last saw the deceased alive on* 13 July, 1967, *and that death occurred at* 9:20P m., *from the causes and on the date stated above.*

23a. SIGNATURE James H. Gafford 489 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 7.14.67

24a. BURIAL, CREMATION, REMOVAL (Specify) 7.17.67 Burial
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 7-18-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER
LICENSE NO. 343
FIRM NAME: White Mortuary TwinFalls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-62021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 21 1967 Bureau of Vital Statistics

State File No. 3236
Local Reg. No. D-250
Reg. Dist. No. 4-0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 43

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Twin Falls
d. STREET ADDRESS (If rural, give location) R.R.#3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Christopher	J.	Green	July 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 15, 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Rancher-Cattleman	04	Pinxten-Derbysgire, England	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unknown	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-01-7620	Jennie Green	Twin Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 20 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Infarction. — I think
DUE TO (c) Coronary Artery Disease. — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/13, 19 67, *to* 7/13/, 19 67, *that I last saw the deceased alive on* 7/13, 19 67, *and that death occurred at* 11:44a. m., *from the causes and on the date stated above.*

23a. SIGNATURE		23b. ADDRESS	23c. DATE SIGNED
Ray V. Straub	466 (Degree or title) M.D.	Twin Falls, Idaho	7/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/17/67	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-18-67	Pamela J. Johnson	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3237
Local Reg. No. D-349
Reg. Dist. No. 460

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Filer
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) R.R.#1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Filer
d. STREET ADDRESS (If rural, give location) R.R.#1

3. NAME OF DECEASED (Type or Print) a. (First) FLORA b. (Middle) c. (Last) KUSY

4. DATE OF DEATH (Month) (Day) (Year) July 14, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH April 2, 1883

9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Canada Charlotte Town, Prnc. Edw. Island

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Michael Currey BIRTHPLACE Canada

14. MOTHER'S MAIDEN NAME unknown BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-24-6108B

17. INFORMANT'S OWN SIGNATURE Frank Kusy ADDRESS Filer, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7220

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 7 dy.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Rheumatoid Arthritis-advanced — 22 yrs.

DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1964, *to* 7/14/, 1967, *that I last saw the deceased alive on* 7-7, 1967, *and that death occurred at* 4:00a. m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward A Rees 43 (Degree or title) M.D. **23b. ADDRESS** Twin Falls, Idaho **23c. DATE SIGNED** 9/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** 7/18/67 **24c. NAME OF CEMETERY OR CREMATORY** I.O.O.F. Cemetery **24d. LOCATION** (City, town, or county) Filer, Idaho (State)

DATE REC'D BY LOCAL REG. 7-18-67 **REGISTRAR'S SIGNATURE** Pamela Johnson

25. EMBALMER Paul D. Reynolds Paul D. Reynolds LICENSE NO. E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 21 1967 Bureau of Vital Statistics

State File No. 3238
Local Reg. No. 0-234
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 222 Shoshone St. West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 42 T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 459 2nd Ave. North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ALBERT	V.	ACKERMAN	July 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	December 12, 1902	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Electrician 09		Kenton, Ohio	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Ackerman	unknown	Valentina Flannagan	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		283-07-9025	Mrs Helen Canna	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4168 Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Arrhythmia — ?
DUE TO (c) Rheumatic Heart Disease — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did not attend, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 9:15a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. Thad Scholes MD 583	Coroner 4	Twin Falls, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7/21/67	Sunset Mem. Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-67	Pamela J. Johnson	James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 14 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-7111

BIRTH NO.

Certificate of Death

STATE OF IDAHO

RECEIVED JUL 21 1967 Bureau of Vital Statistics

State File No. 3239
Local Reg. No. D-233
Reg. Dist. No. 460

1. PLACE OF DEATH

a. COUNTY 42 Twin Falls

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

LENGTH OF STAY (in this place) 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho b. COUNTY 42 T. Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

d. STREET ADDRESS (If rural, give location) 1871 4th Ave. East

3. NAME OF DECEASED (Type or Print)

a. (First) Heidi Lori b. (Middle) Jo c. (Last) Sonius

4. DATE OF DEATH (Month) (Day) (Year) July 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never married	July 15, 1967	0	0	0		1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Dennis Sonius BIRTHPLACE Spencer, Iowa

14. MOTHER'S MAIDEN NAME Nancy McKnight BIRTHPLACE Elma, Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Pamela Sonius ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) FETAL ASPHYXIA — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) MATERNAL DIABETES

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. DOWN'S SYNDROME

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/15/ , 19 67, *to* 7/15/67 , 19 67, *that I last saw the deceased alive on* 7/15/ , 19 67, *and that death occurred at* 11:46a. m., *from the causes and on the date stated above.*

23a. SIGNATURE V. V. Rexford 525 (Degree or title) M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 7/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/18/67

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 7-19-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER James C. Reynolds James C. Reynolds LICENSE NO. E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3240
Local Reg. No. 0-261
Reg. Dist. No. 460

RECEIVED JUL 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. View Nursing Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Twin Falls
d. STREET ADDRESS (If rural, give location) R.R. 32

3. NAME OF DECEASED (Type or Print) a. (First) FLOYD b. (Middle) W. c. (Last) HOLLOWAY

4. DATE OF DEATH (Month) (Day) (Year) July 16, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH May 8, 1900

9. AGE (In years last birthday) 67
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Landscape Gardner

10b. KIND OF BUSINESS OR INDUSTRY 04

11. BIRTHPLACE (State or foreign country) Nez Perce, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Holloway BIRTHPLACE Terre Haute, Ind.

14. MOTHER'S MAIDEN NAME Dollie E. Crewese BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-28-5180A

17. INFORMANT'S OWN SIGNATURE x Mrs. Thelma Holloway ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Chronic Emphysema — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-22, 1954, *to* 7/16/, 19 67, *that I last saw the deceased alive on* 7-16, 1967, *and that death occurred at* 9:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Dean H. Affleck (Degree or title) M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 26 July 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7/21/67

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 7-26-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER James C. Reynolds James C. Reynolds

LICENSE NO. E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 09 1999

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician:

Certificate of Death

STATE OF IDAHO

State File No. 3241
Local Reg. No. D-257
Reg. Dist. No. 460

RECEIVED JUL 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 020 Twin Falls
b. CITY OR TOWN Kimberly
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Mt. View Conval. Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls 421
c. CITY OR TOWN Twin Falls
d. STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print)
a. (First) ELLA
b. (Middle) M.
c. (Last) CORDES

4. DATE OF DEATH (Month) (Day) (Year) July 17, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow
8. DATE OF BIRTH Mar. 17th, 1874
9. AGE (In years last birthday) 93
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cedar City, Iowa
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Nathaniel Tolbert
BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Caroline Roesher
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-54-0777
17. INFORMANT'S OWN SIGNATURE Anna C. Davis
ADDRESS R#1 Twin Falls Ida

4918

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility (Fifth fracture of femur) — INTERVAL BETWEEN ONSET AND DEATH: 7/11/67

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchopneumonia + cystitis — 7/10/67
DUE TO (c) Cerebral Embolism — 1 day

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) no
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 47, *to* 7/17, 19 67, *that I last saw the deceased alive on* 7/17/67, 19____, *and that death occurred at* 1:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE George C. Halley (Degree or title) M.D.
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 7/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7.19.67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. 7-18-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER
LICENSE NO. 343

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 27 1967

SEP 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JUL 28 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3242
Local Reg. No. 0-338
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 4 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 1009 McCollum

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 1009 McCollum

3. NAME OF DECEASED (Type or Print) a. (First) ALTA b. (Middle) M c. (Last) UNDERBERG

4. DATE OF DEATH (Month) July (Day) 19 (Year) 1967

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH Mar. 17, 1883

9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fruit Grower 04

10b. KIND OF BUSINESS OR INDUSTRY Fruit Grower

11. BIRTHPLACE (State or foreign country) Stanton, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Chas. W. Underberg — BIRTHPLACE New York

14. MOTHER'S MAIDEN NAME Helene Zibbler — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 522-50-2529-A

17. INFORMANT'S OWN SIGNATURE Lon Wist — ADDRESS Buhl

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — years
DUE TO (c) and Fall-striking head

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

331 X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jul 7, 1965 *to* July 19, 1967, *that I last saw the deceased alive on* July 19, 1967 *and that death occurred at* 5:15 pm *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD

23b. ADDRESS 122 9th Ave No Buhl

23c. DATE SIGNED 7-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3

24b. DATE July 24, 1967

24c. NAME OF CEMETERY OR CREMATORY Palisade, Coloado

24d. LOCATION (City, town, or county) (State) Palisade, Colorado

DATE REC'D BY LOCAL REG. 7-25-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER George Farmer — LICENSE NO. E-480

FIRM NAME Albertson-Packard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3243
Local Reg. No. D-257
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED
JUL 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 743 Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
d. STREET ADDRESS (If rural, give location) Filer Motel

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE
b. (Middle)
c. (Last) ANDROFF

4. DATE OF DEATH (Month) (Day) (Year) July 19 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never Married
8. DATE OF BIRTH April 23, 1879
9. AGE (In years last birthday) 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheep Herder 04
10b. KIND OF BUSINESS OR INDUSTRY livestock
11. BIRTHPLACE (State or foreign country) Bulgaria
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME No Record — BIRTHPLACE
14. MOTHER'S MAIDEN NAME No Record — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-60-3064-B
17. INFORMANT'S OWN SIGNATURE Charles C. Conrad — ADDRESS Castleford

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Pneumonia — Days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes Mellitus — Months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 7, 1967, *to* July 19, 1967, *that I last saw the deceased alive on* July 19, 1967, *and that death occurred at* 4:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE C. A. Cullington (Degree or title)
23b. ADDRESS 1229 4th Ave No Buhl
23c. DATE SIGNED 7-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 24, 1967
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) Buhl (State) Idaho

DATE REC'D BY LOCAL REG. 7-25-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER George Farmer
LICENSE NO. E-480
FIRM NAME Albertson Richard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3244
Local Reg. No. D-266
Reg. Dist. No. 460

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
c. LENGTH OF STAY (in this place) I year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) residence, 4m South, I east 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Castleford
d. STREET ADDRESS (If rural, give location) R.F.D.#I, Buhl

3. NAME OF DECEASED (Type or Print)
a. (First) BRUCE
b. (Middle) MARION
c. (Last) GRAY

4. DATE OF DEATH (Month) July (Day) 20 (Year) I967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH July 24, I90I
9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Sheep growing
11. BIRTHPLACE (State or foreign country) Ft. Collins, Colo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John L. Gray — BIRTHPLACE Kentucky
14. MOTHER'S MAIDEN NAME ✓ — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 545-22-322I
17. INFORMANT'S OWN SIGNATURE Mrs. Iona Gray — ADDRESS Buhl

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Infarction of Myocardium — INTERVAL BETWEEN ONSET AND DEATH 15 mins

ANTECEDENT CAUSES due to Coronary Sclerosis

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 20, 1967, *to* July 20, 1967, *that I last saw the deceased alive on* July 20, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Vern H Anderson, M.D. 011 (Degree or title)
23b. ADDRESS Buhl, Ida
23c. DATE SIGNED 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 25, I967
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) Buhl, (State) Idaho

DATE REC'D BY LOCAL REG. 8-4-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER George Farmer — LICENSE NO. E-480
Albertson - Dickard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 17 1986

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3245
Local Reg. No. D-259
Reg. Dist. No. 460

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazel Dell Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 028
b. COUNTY Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ketchum
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) FRANCES
b. (Middle) LAWRENCE
c. (Last) SCOTT

4. DATE OF DEATH (Month) (Day) (Year) July 20, 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH May 7, 1887
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Philadelphia, Penn.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Larence — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Ella Fagan — BIRTHPLACE Irland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-62-4634
17. INFORMANT'S OWN SIGNATURE Edward L. Scott — ADDRESS Ketchum, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A. terminal — INTERVAL BETWEEN ONSET AND DEATH short time

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Old age Gen debility
hemiplegia Gen arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hertz of 3 strokes prior to this one

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1965, *to* July 17, 1967, *that I last saw the deceased alive on* 7-17-, 1967, *and that death occurred at* 4 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE M A Drake M.D. 146 (Degree or title) 1
23b. ADDRESS 594 Hoyt del drive
23c. DATE SIGNED 7-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/22/67
24c. NAME OF CEMETERY OR CREMATORY Ketchum Cemetery
24d. LOCATION (City, town, or county) Ketchum, (State) Idaho

DATE REC'D BY LOCAL REG. 7-31-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Keith Bird Keith Bird — LICENSE NO. E-373
FIRM NAME Bird Funeral Home, Hailey, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 0 4 1994

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3246
Local Reg. No. 1-260
Reg. Dist. No. 460

RECEIVED JUL 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
c. STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mountain View Convalescent

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sarah
b. (Middle): Ann
c. (Last): Adams

4. DATE OF DEATH: July 21, 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: April 7, 1878

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR — Months: 3 Days: 14
IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Heywood, Langshire, England

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ellis Sottonstall,
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Ann Parks
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-46-3303

17. INFORMANT'S OWN SIGNATURE: Mrs Leonard Ure
ADDRESS: Hansen, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia - 4438 — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertensive Cardiovascular Dis — 5 yrs

DUE TO (c) Cerebro Vascular Accident Responsible — 8 mo

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July, 1952, *to* July 21, 1967, *that I last saw the deceased alive on* July 21, 1967, *and that death occurred at* 5:05 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE: D. Ellis Livingston (Degree or title): MD

23b. ADDRESS: Kimberly, Ida.

23c. DATE SIGNED: July 24-1967.

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: July 26, 1967

24c. NAME OF CEMETERY OR CREMATORY: Marion Cemetery

24d. LOCATION (City, town, or county) (State): Marion, Cassia Co. Idaho

DATE REC'D BY LOCAL REG.: 7-26-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Ormand Burch

LICENSE NO.: E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3247
Local Reg. No. D-256
Reg. Dist. No. 460

RECEIVED JUL 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print) a. (First) George b. (Middle) D. c. (Last) Roberts

4. DATE OF DEATH (Month) (Day) (Year) July 21, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH June 4, 1898

9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Tarkio, Missouri

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME William Roberts BIRTHPLACE New York

14. MOTHER'S MAIDEN NAME Agnes Strain BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI US Army 3

16. SOCIAL SECURITY NO. 519-07-9563A

17. INFORMANT'S OWN SIGNATURE Mrs. George D. Roberts ADDRESS Twin Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: Unknown - to last 2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Perforated Marginal Ulcer — 2 wks.
DUE TO (c) Chronic Pancreatitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Perforated Duodenal Stump. — 2 wks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 1965, to 7/21, 1967, that I last saw the deceased alive on 7/20, 1967, and that death occurred at 1A. m., from the causes and on the date stated above.

23a. SIGNATURE Loyd S. Wahl M.D. 466 (Degree or title)

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 7.21.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7.24.67

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cem.

24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. 7-24-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER

LICENSE NO. 343

FIRM NAME White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 31 1967

AUG 3 1967

FEB 23 1988 VA

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3248
Local Reg. No. D-262
Reg. Dist. No. 460

67-7128
BIRTH NO.

Certificate of Death

STATE OF IDAHO

RECEIVED AUG - 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
d. STREET ADDRESS (If rural, give location) Rural Route #2

3. NAME OF DECEASED (Type or Print)
a. (First) ANGELLA
b. (Middle)
c. (Last) MORRILL

4. DATE OF DEATH (Month) (Day) (Year) July 23, 1967

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH July 23, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours 16 Min. 00

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME G. Doyle Morrill
BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Betty Ann Kelson
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NO
17. INFORMANT'S OWN SIGNATURE H. G. Doyle Morrill
ADDRESS Rt. #2 Kimberly

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7735

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pre-eclampsia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 16 hours

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 23, 1967, *to* July 23, 1967, *that I last saw the deceased alive on* July 23, 1967, *and that death occurred at* 8:45 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Charles W. Schobacher 456 (Degree or title)
23b. ADDRESS 111 6th Ave E. Twin Falls
23c. DATE SIGNED 7-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 26, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. 7-27-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3249
Local Reg. No. 0-364
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 248 Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Tuttle
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Francis c. (Last) Ravenscroft

4. DATE OF DEATH (Month) July (Day) 24, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 18-Oct. 1894

9. AGE (In years last birthday) 72 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Eureka, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Turner Lee Ravenscroft BIRTHPLACE W. Virginia

14. MOTHER'S MAIDEN NAME Lula Hawthorne BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) None

16. SOCIAL SECURITY 518-42-6702

17. INFORMANT'S OWN SIGNATURE Fern L Ravenscroft ADDRESS Tuttle, Ida.

18. CAUSE OF DEATH 584X
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Cholecystitis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cholelithiasis — 3 wks
~~DUE TO~~ (c) Cerebral vascular accident — 2 hrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, generalized

19a. DATE OF OPERATION 7-20-67

19b. MAJOR FINDINGS OF OPERATION Chronic Cholecystitis and Cholelithiasis

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-18, 1967, *to* 7-24, 1967 *that I last saw the deceased alive on* 7-24-67, 19___, *and that death occurred at* 3:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 551 George W. Warner M.D.

23b. ADDRESS 111 6th Ave E. Twin Falls

23c. DATE SIGNED 7/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 7-27-67

24c. NAME OF CEMETERY OR CREMATORY Wendell Cemetery

24d. LOCATION (City, town, or county) (State) Wendell Gooding Idaho

DATE REC'D BY LOCAL REG. 8-1-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Robert L Meyer

LICENSE NO. E-424

FIRM NAME: Thompson Chapel Gooding, Ida

Federal Security Agency
United States Public Health Service

Form DH-6202I

AUG 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3250
Local Reg. No. D-263
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG - 3 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Oregon Trail Motel 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 05 California
b. COUNTY 555 Riverside
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Palm Springs
d. STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MILDRED	RUTH	KINGERY	July	25	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	never married	March 27, 1906	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Registered Nurse 23	Nursing	Little Rock, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William O. Kingery	Pennsylvania	Mary Elizabeth Stiefel	Penn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unknown	519-24-2726	Edith M. Everson	Cathedral City Calif

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 8:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward Cullings MD	122 9th Ave No Buhl Idaho	7/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	July 28, 1967	Mountain View Memorial	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-31-67	Pamela J. Johnson	George Farmer	E-480

NAME OF FUNERAL DIRECTOR OR PERSON ACTING AS SUCH: Albertson-Pickard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 28 1967

OCT 10 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 24 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3251
Local Reg. No. D-294
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 127 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 26 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 611 3rd Ave. East

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 611 3rd Ave. East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAMES	FLOYD	MAYS	July 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	July 20, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	own farm	Morgan County, Kentucky	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Mays	Kentucky	Magnolia Cox	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- - - - - -	493-12-2467	Mrs Edna Mays	Twin Falls Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary congestion & edema — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Virus pneumonia — 7 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, generalized, with bilateral arterionarnephrosclerosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none recently		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - -	- - - - - -	- - - - - - - - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
- - - - - - m.		- - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* 1-4, 1954, *to* 7-28, 1967, *that I last saw the deceased alive on* 7-28, 1967, *and that death occurred at* 11:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marvin M. Ford M.D.	Twin Falls, Idaho	8-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	8-1-1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/22/67	Vera Ryals	Alice L. Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3252
Local Reg. No. 2254
Reg. Dist. No. 460

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY 42/ Twin Falls 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls | LENGTH OF STAY (In this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 42/ b. COUNTY Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

d. STREET ADDRESS (If rural, give location) 1151 10th Av. E.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JEFFERY	143	McFARLAND	July 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Single /	March 11, 1955	12				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03		Twin Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Morris McFarland	Utah	Edgatina Tyler	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		NONE	Morris McFarland	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Asphyxiation	one hour
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Bronchial Obstruction	?
DUE TO (c)	Bronchial Asthma	Years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Investigation Only, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Thad Scholes M.D. 583 F. County Coroner 4	Twin Falls, Idaho	7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 31, 1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-8-67	Pamela J. Johnson	X	E-343

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service

Form DH-630 21

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3253
Local Reg. No. 0-272
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eden
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) ETHEL
b. (Middle) FLORA
c. (Last) NICKERSON

4. DATE OF DEATH (Month) (Day) (Year) July 28, 1967

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH August 12, 1909
9. AGE (In years last birthday) 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Dwight, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Clifton Carl Spangler — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Nellie Edith Yocum — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-12-8136
17. INFORMANT'S OWN SIGNATURE Bert Nickerson — ADDRESS Eden, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Metastases — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pseudo mucinous cystadeno - carcinoma — 3 years
DUE TO (c) from left ovary

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1750

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-4, 1960, *to* 7-28, 1967, *that I last saw the deceased alive on* 7-27-, 1967, *and that death occurred at* 7:10 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE Dean H Abblech 003 (Degree or title)
23b. ADDRESS 231-4th Ave. North Twin Falls, Idaho
23c. DATE SIGNED 28 July 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 31, 1967
24c. NAME OF CEMETERY OR CREMATORY Hazelton, Cemetery
24d. LOCATION (City, town, or county) (State) Hazelton, Idaho

DATE REC'D BY LOCAL REG. 8-8-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER [signature]
LICENSE NO. E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary

AUG 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3254
Local Reg. No. D-223
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 157 Twin Falls
b. CITY OR TOWN Twin Falls
LENGTH OF STAY (in this place) 57 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 561 Alturas Drive

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 561 Alturas Drive

3. NAME OF DECEASED (Type or Print) a. (First) ADA b. (Middle) W. c. (Last) HARDER

4. DATE OF DEATH (Month) July (Day) 29, (Year) 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH Dec. 23, 1888

9. AGE (In years last birthday) 78 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) St. Edwards, Nebraska

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Unknown BIRTHPLACE

14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-12-7368

17. INFORMANT'S OWN SIGNATURE Richard L. Harder ADDRESS Twin Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 10 mins ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic HD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jun, 1967, *to* Jun 29, 1967, *that I last saw the deceased alive on* Jun 28, 1967, *and that death occurred at* 4 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Willard M. Peterson MD (Degree or title) 417

23b. ADDRESS Twin Falls Idaho

23c. DATE SIGNED 7-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE August 1, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) Twin Falls, (State) Idaho

DATE REC'D BY LOCAL REG. 8-8-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER

LICENSE NO. E-343

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3255
Local Reg. No. 0-263
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
AUG 8 - 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 113
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 13 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 508 8th Ave. North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 508 8th Ave. North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	GROVER	C.	PRUETT	July 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 2, 1892	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 64	Agriculture	Hartville, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Pruett	No Record	No Record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-01-3685	Jewel Pruett	508 8th Ave. Buhl, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4201 Infarction of Myocardium — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) due to Coronary Sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan 1, 1967, *to* July 29, 1967, *that I last saw the deceased alive on* July 29, 1967, *and that death occurred at* 6:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern H Anderson MD	Buhl Ida	8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/1/67	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-4-67	Pamela J. Johnson	Robert F. Dickard	E-312

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3256
Local Reg. No. 0270
Reg. Dist. No. 460

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 / Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) Penny Bldg. Jefferson Street

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle) Lucille
c. (Last) Lippincott

4. DATE OF DEATH (Month) July (Day) 31, (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH Feb. 13, 1896

9. AGE (In years last birthday) 71
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY Education

11. BIRTHPLACE (State or foreign country) Silver City, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Dr. Albert C. Lippincott
BIRTHPLACE Maine

14. MOTHER'S MAIDEN NAME Mary Elizabeth Hay
BIRTHPLACE Idaho City Id

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-38-5319

17. INFORMANT'S OWN SIGNATURE Lois L. Rheem
ADDRESS 420 Franklin Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-31, 1967, *to* 7-31, 1967, *that I last saw the deceased alive on* 7-31, 1967, *and that death occurred at* 7:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)
A. W. Kendall M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED Aug. 1, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 4, 1967

24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 8 8 67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Donald J. Hamilton

LICENSE NO. E-470

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 15 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3257
Local Reg. No. 74
Reg. Dist. No. 510

RECEIVED
JUL 24 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) rural
STATE (In this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1 mi. north Smith's Ferry

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1311 West Jefferson

3. NAME OF DECEASED (Type or Print) a. (First) MERLIN b. (Middle) FINLEY c. (Last) McKEE

4. DATE OF DEATH (Month) (Day) (Year) July 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Nov. 9, 1907	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
shoe salesman 34	Bon Marche dept store	Marysville, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
E. J. McKee	USA	Anna Randolph	USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	---	511-09-6037	Evelyn L. McKee	510 S. 3rd E Mtn. Home, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) SUSPECTED FRACTURE OF NECK — INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident	highway/river 06	CASCADE 13	430 Valley	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
m.		driver of auto that crashed from highway into river

22. *I hereby certify that I attended the deceased from* NEVER *19__, to __, 19__, that I last saw the deceased alive on* NEVER *19__, and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John F. Moon	376 MD	CASCADE, IDA	7/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
burial	July 15'67	Cloverdale Cemetery	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 20 1967	Maude M. Gardner	F. Mahard Reed	E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 25 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 19 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3258
Local Reg. No. 15
Reg. Dist. No. 310

BIRTH NO.

RECEIVED JUL 24 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
LENGTH OF STAY (in this place) 12½ wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 430 Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cascade
d. STREET ADDRESS (If rural, give location)

203
152

3. NAME OF DECEASED (Type or Print) a. (First) WINSTON b. (Middle) S. c. (Last) MUNROE

4. DATE OF DEATH (Month) (Day) (Year) July 14, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 15, 1921
9. AGE (In years last birthday) 45 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Radar Elec. Tech. 21
10b. KIND OF BUSINESS OR INDUSTRY Fed. Aviation Agency
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Scott Munroe BIRTHPLACE Washington D. C.
14. MOTHER'S MAIDEN NAME Leatha Brickey BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 2 & Korea 7
16. SOCIAL SECURITY NO. 393-12-0484
17. INFORMANT'S OWN SIGNATURE Eleanor J. Munroe ADDRESS Cascade, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Epidermoid Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* 4-11, 1967, *to* 7-14, 1967, *that I last saw the deceased alive on* 7-14, 1967, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE 500 James H Stewart MD (Degree or title)
23b. ADDRESS Cascade, Idaho
23c. DATE SIGNED 7/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE July 17, '67
24c. NAME OF CEMETERY OR CREMATORY Margaret Cemetery
24d. LOCATION (City, town, or county) Cascade, (State) Idaho

DATE REC'D BY LOCAL REG. July 20 1967
REGISTRAR'S SIGNATURE Myrtle A. Gardner
25. EMBALMER Burton C Walker
LICENSE NO. E-386
FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 23 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Diagnosis by biopsy 4-22-67.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3259
Local Reg. No.
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 030 Valley 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (in this place) 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Nursing Home 327

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 020
b. COUNTY Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fruitvale
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) R. c. (Last) MC GINLEY

4. DATE OF DEATH (Month) (Day) (Year) July 20, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Jan. 14, 1884

9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) cook 07

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Council, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Robertson — BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Martha Harp — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-01-8787

17. INFORMANT'S OWN SIGNATURE Trude Glenn ADDRESS ,Fruitvale,Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 30 MIN.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS — 4 YEARS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* APRIL, 1967, *to* JULY, 1967, *that I last saw the deceased alive on* MAY 21, 1967, *and that death occurred at* 2:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE Ronald L. Mokes M.D. (Degree or title)

23b. ADDRESS McCALL, IDAHO

23c. DATE SIGNED 8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 24, 1967

24c. NAME OF CEMETERY OR CREMATORY IOOF Cemetery

24d. LOCATION (City, town, or county) Council, (State) Idaho

DATE REC'D BY LOCAL REG. Aug 9-1967

REGISTRAR'S SIGNATURE Myrtle A. Gardner

25. EMBALMER Burton C Walker

LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3260
Local Reg. No. 19
Reg. Dist. No. 30

BIRTH NO.

RECEIVED AUG 11 1967 Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 420 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give) McCall
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA McCall Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 020 Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Meadows
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) RHONDA b. (Middle) LYNN c. (Last) TINSLEY

4. DATE OF DEATH (Month) (Day) (Year): July 31, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: July 30, 1965

9. AGE (In years last birthday): 2 | If under 1 year: Months | Days: 1 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): McCall, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oris Tinsley — BIRTHPLACE: Manes, Missouri

14. MOTHER'S MAIDEN NAME: Bessie Bennett — BIRTHPLACE: Grow Springs, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Oris Tinsley — ADDRESS: New Meadows, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8304

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aspiration of blood
DUE TO (c) Severe crush injury of head

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): House

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): New Meadows Adams 020 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7 31 67 7:00 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Hit with car in own driveway

22. *I hereby certify that I attended the deceased from* 7-31, 1967, *to* 7-31, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 7:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wayne F. Allen MD (Degree or title)

23b. ADDRESS: McCall Idaho

23c. DATE SIGNED: 8-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 4, 1967

24c. NAME OF CEMETERY OR CREMATORY: Meadows Valley

24d. LOCATION (City, town, or county) (State): Meadows Idaho

DATE REC'D BY LOCAL REG.: Aug-8-1967

REGISTRAR'S SIGNATURE: Myrtle R. Gardner

25. EMBALMER: Burton E. Walker

LICENSE NO.: E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-69021

AUG 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3261
Local Reg. No. 2
Reg. Dist. No. 320

BIRTH NO.

JUL 19 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 44 Washington

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho

b. COUNTY 447 Washington

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)

a. (First) Lydia

b. (Middle) Jane 153

c. (Last) Jones

4. DATE OF DEATH (Month) 7 (Day) 1 (Year) 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH 12/19/1886

9. AGE (In years last birthday) 80 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) Competition, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Emmerson — BIRTHPLACE --

14. MOTHER'S MAIDEN NAME Margaret Hutsel — BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE X Ed Simmons — ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) C.V.A.

DUE TO (c) Cerebral Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Senility

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-26-, 1967, *to* 7-1-, 1967, *that I last saw the deceased alive on* 7-1-, 1967, *and that death occurred at* 11:55 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 344

23b. ADDRESS Weiser, Idaho

23c. DATE SIGNED 7/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal B

24b. DATE 7/6/67

24c. NAME OF CEMETERY OR CREMATORY Star Cemetery

24d. LOCATION (City, town, or county) Star (State) Idaho

DATE REC'D BY LOCAL REG. 7-3-67

REGISTRAR'S SIGNATURE L. Dee Thomsen

25. EMBALMER Marshall S. Dickerson Jr.

LICENSE NO. E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3262
Local Reg. No. 3
Reg. Dist. No. 320

Certificate of Death

RECEIVED
JUL 19 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 441 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 441
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): EDWARD
b. (Middle): W.
c. (Last): KUNTZ

4. DATE OF DEATH (Month) (Day) (Year): July 4 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: 9/17/1881
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months 9, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Deadwood, South Dakota
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Phillip Kuntz — BIRTHPLACE: -----
14. MOTHER'S MAIDEN NAME: Emma Froescher — BIRTHPLACE: -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Donna Womack — ADDRESS: Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypostatic Pneumonia
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c): Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-25-, 1967 *to* 7-4-, 1967, *that I last saw the deceased alive on* 7-4-, 1967, *and that death occurred at* 10:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 344 (Degree or title)
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 7/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/7/67
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county): Weiser — (State): Idaho

DATE REC'D BY LOCAL REG.: 7/4/67
REGISTRAR'S SIGNATURE: R. Dale Thomason
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUL 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3263
Local Reg. No. 1
Reg. Dist. No. 320

BIRTH NO.

RECEIVED JUL 1967 BUREAU OF VITAL STATISTICS

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 44/ Washington
b. CITY OR TOWN Weiser
c. LENGTH OF STAY (in this place) OOV
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 44/ Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) Pioneer Road

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Doris	Bonnie	Hendry	7	4	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	married 3	3/31/1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Decatur, Ill.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
----	----	-----	-----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			+ Clarence L Hendry	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Acute Coronary occl.	1 hr.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic H D	5 y
DUE TO (c)	Gen arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6/2, 1956, *to* 7/4, 1967, *that I last saw the deceased alive on* 1/30, 1967, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
186 (Degree or title)	Weiser, Idaho	7/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	7/8/67	Hillcrest	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-7-67	L. Dee Thomson	Marshall S. Dechesne	E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3264
Local Reg. No. 6
Reg. Dist. No. 320

RECEIVED
JUL 28 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington 306
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
d. STREET ADDRESS (If rural, give location) 337 Holly

3. NAME OF DECEASED (Type or Print)
a. (First) EVA
b. (Middle) B.
c. (Last) JOHNSON

4. DATE OF DEATH (Month) July (Day) 13, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH February 20, 1887
9. AGE (In years last birthday) 80 — If under 1 year: Months – Days – If under 24 hrs.: Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William A. Pratt — BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Amanda Stroupe — BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 519-62-3531
17. INFORMANT'S OWN SIGNATURE Mrs Warren Loomis — ADDRESS New Meadows Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 331X C.V.A.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) - - - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - - - - -
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? - - - - -

22. *I hereby certify that I attended the deceased from* 7-7-, 1967, *to* 7-13-, 1967, *that I last saw the deceased alive on* 7-13-, 1967, *and that death occurred at* 1:55A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 344 (Degree or title) 1
23b. ADDRESS
23c. DATE SIGNED 7-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial 3
24b. DATE July 15, 1967
24c. NAME OF CEMETERY OR CREMATORY Park View Cemetery
24d. LOCATION (City, town, or county) New Plymouth (State) Idaho

DATE REC'D BY LOCAL REG. 7-13-67
REGISTRAR'S SIGNATURE R. Dee Thomason
25. EMBALMER Gifford R. Shaffer — LICENSE NO. E-344
FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3265
Local Reg. No. 4
Reg. Dist. No. 320

BIRTH NO.

RECEIVED JUL 27 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 441 Washington 000
b. CITY OR TOWN Weiser
c. If outside corporate limits, write RURAL and give township. | If Dead on Arrival, Specify | If Other Than Usual Place of Residence, Specify Usual Place of Residence | If Usual Residence Unknown, Specify Length of Stay (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 441 Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 335 W. Court

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE
b. (Middle) L. 153
c. (Last) PETRASHEK

4. DATE OF DEATH (Month) July (Day) 15 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH 11/2/86

9. AGE (In years last birthday) 80 | If under 1 year: Months 8 | Days 13 | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner 22

10b. KIND OF BUSINESS OR INDUSTRY Feed & Seed Co.

11. BIRTHPLACE (State or foreign country) Humboldt, Nebraska

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Joseph Petrashek
BIRTHPLACE ----

14. MOTHER'S MAIDEN NAME Kate
BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) W.W.I 3

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Hazel M. Petrashek
ADDRESS Weiser

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia
INTERVAL BETWEEN ONSET AND DEATH 24 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebro-vascular accident 5 d
DUE TO (c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/29, 1967 *to* 7/15, 1967, *that I last saw the deceased alive on* 7/14, 1967, *and that death occurred at* 2:35 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD

23b. ADDRESS Weiser, Idaho

23c. DATE SIGNED 7/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE 7/18/1967

24c. NAME OF CEMETERY OR CREMATORY Mountainview Mausoleum & Crematorium

24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 7/15/67

REGISTRAR'S SIGNATURE K. Dale Thomason

25. EMBALMER K. Dale Thomason
LICENSE NO. E-388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JUL 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 21 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 20 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 30 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3266
Local Reg. No. 7
Reg. Dist. No. 320

Certificate of Death

RECEIVED
JUL 28 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 153 Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 441
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) May
b. (Middle) Elizabeth
c. (Last) Walker

4. DATE OF DEATH (Month) 7 (Day) 16 (Year) 67

5. SEX female
6. COLOR OR RACE caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH 5/22/1889
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Sedan, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John W. Walker — BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME Laura Belle Pearson — BIRTHPLACE -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE x Ralph Walker — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1538 Metastatic Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ca. Colon
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-8, 1967, *to* 7-16, 1967, *that I last saw the deceased alive on* 7-16, 1967, *and that death occurred at* 10:15 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE 344 [signature] (Degree or title)
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED 7/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 7/19/67
24c. NAME OF CEMETERY OR CREMATORY Hillcrest
24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. 7-19-67
REGISTRAR'S SIGNATURE R. Dale Thomason
25. EMBALMER R. Dale Thomason
LICENSE NO. E 388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ~~ALL PARTS OF THIS ITEM.~~ ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3267
Local Reg. No. 5
Reg. Dist. No. 320

BIRTH NO.

RECEIVED JUL 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 44 Washington 313
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
LENGTH OF STAY (in this place) 13 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Haven Nursing Home 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 38 Oregon
b. COUNTY 555 Malheur
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ontario
d. STREET ADDRESS (If rural, give location) Route 1 Box 226

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Bert		Koplin	July	17	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Sept 27, 1876	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer Machinest 04	Retired	Lowell Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Simon Koplin	Lowell Penn.	Elizabeth Knisley	Lowell Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO			Mrs. Fred Trinkle, via telephone, Onte, Ore	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 794X Senility — INTERVAL BETWEEN ONSET AND DEATH gradual

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1935, 19__, *to* July 17, 1967, *that I last saw the deceased alive on* June 1, 1967 *and that death occurred at* 3 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
694 Charles E. Palmer M.D.	Ontario, Oregon	7/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7-20-67	Evergreen	Ontario Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-19-67	K. Dee Thomason	John A. Lienhaemper	ORE. 120

FIRM NAME Bertelson-Lienhaemper

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3268
Local Reg. No. 8
Reg. Dist. No. 320

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 440
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cambridge
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) HILDRED
b. (Middle) ANNA 153
c. (Last) JONES

4. DATE OF DEATH (Month) July (Day) 21 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 11/5/1910
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR Months 8 Days 16 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Sabetha, Kansas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Fredrick E. Burch — BIRTHPLACE Woodston, Kan.
14. MOTHER'S MAIDEN NAME Helen B. Vermillon — BIRTHPLACE Sabetha, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Elmer R. Jones — ADDRESS Cambridge

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 331X C.V.A.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-16-, 1967, *to* 7-21-, 1967, *that I last saw the deceased alive on* 7-21-, 1967, *and that death occurred at* 4:47 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 344 (Degree or title)
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED 7/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 7/24/1967
24c. NAME OF CEMETERY OR CREMATORY Indian Valley Cem.
24d. LOCATION (City, town, or county) Indian Valley, (State) Idaho

DATE REC'D BY LOCAL REG. 7/21/67
REGISTRAR'S SIGNATURE R. Dave Thomason
25. EMBALMER R. Dave Thomason
LICENSE NO. E-388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 11 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 24 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3269
Local Reg. No. 9
Reg. Dist. No. 320

BIRTH NO.

RECEIVED AUG 7 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 44 Washington
b. CITY OR TOWN Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 44 Washington
c. CITY OR TOWN Weiser
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Dale	C.	Laird	7	23	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	caucasian	married 3	6/5/1887	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farming	Lawrence, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Paschal Laird	------	Lizzie	-----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Mrs Dale Laird	Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C. V. A.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-21- , 1967, *to* 7-23- , 1967, *that I last saw the deceased alive on* 7-23- , 1967, *and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. D. McGrath	Weiser, Idaho	7/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal 3	7/25/67	Fairfield Cemetery	Fairfield, Nebraska

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-25-67	K. Dale Thomason	K. Dale Thomason	E 388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 25 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 19 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3270
Local Reg. No. 10
Reg. Dist. No. 320

BIRTH NO. 67-7160

Certificate of Death

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY 441 Washington 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (If not in place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 441
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle) --------
c. (Last) Weeks

4. DATE OF DEATH (Month) (Day) (Year)

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH 7/18/67
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 4 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant 02
10b. KIND OF BUSINESS OR INDUSTRY infant
11. BIRTHPLACE (State or foreign country) Weiser, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME ---------
BIRTHPLACE -----
14. MOTHER'S MAIDEN NAME Mary Robertson Smith
BIRTHPLACE WashingtonDC

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. -------
17. INFORMANT'S OWN SIGNATURE Mary A. Weeks
ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity - 5 mo pg

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/18, 1967 *to* 7/18, 1967 *that I last saw the deceased alive on* 7/18, 1967 *and that death occurred at* 11:55 A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 186 (Degree or title) 3281
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED 7/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE 7/20/67
24c. NAME OF CEMETERY OR CREMATORY Mountain View Crematory
24d. LOCATION (City, town, or county) Boise, (State) Idaho

DATE REC'D BY LOCAL REG. 7/20/67
REGISTRAR'S SIGNATURE R. Dale Thomason
25. EMBALMER Marshall S. Dickerson Jr.
LICENSE NO. E 464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3271
Local Reg. No. 12
Reg. Dist. No. 320

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

AUG 23 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 441 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 441 b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 1505 W. 7th

3. NAME OF DECEASED (Type or Print)
a. (First) FAY b. (Middle) c. (Last) DOHRMANN

4. DATE OF DEATH (Month) July (Day) 26 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 1/16/1900
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY Bldg. Contractor
11. BIRTHPLACE (State or foreign country) Cripple Creek, Colorado
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME William Dohrmann — BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME Margaret Cords — BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W.W.II 4
16. SOCIAL SECURITY NO. 562-09-9815
17. INFORMANT'S OWN SIGNATURE August Dohrmann — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-26-, 1967, *to* 7-26-, 1967, *that I last saw the deceased alive on* 7-26-, 1967, *and that death occurred at* 8:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 344 [signature] McGrath MD
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED 7/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7/29/1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. 7/26/67
REGISTRAR'S SIGNATURE R. Dale Thomason
25. EMBALMER R. Dale Thomason
LICENSE NO. E-388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3272
Local Reg. No. 131
Reg. Dist. No. 371

RECEIVED
SEP 8 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 31 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 508 N. 21st. St.

3. NAME OF DECEASED (Type or Print)
a. (First): Amanda
b. (Middle): K.
c. (Last): Maxon

4. DATE OF DEATH (Month) (Day) (Year): July 11, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 26, 1868
9. AGE (In years last birthday): 98 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Ophir, Nevada
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lawson Hughes — BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Sarah A. Hughes — BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-60-4019
17. INFORMANT'S OWN SIGNATURE: Leroy Maxon — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1992

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Metastatic carcinoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Origin undetermined
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/10/65, 19__, *to* 7/12/67, 19__, *that I last saw the deceased alive on* 7/12/67, 19__, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE 054 (Degree or title): [signature] M.D.
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 8/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 7/14/67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 9-1-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters [signature]
LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service
Form DH-63021 [signature] Helen Olson
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3273
Local Reg. No. 128
Reg. Dist. No. 371

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 30 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 104 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Valley Sunset Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 5706 Franklin Road

3. NAME OF DECEASED (Type or Print)
a. (First) EDNA
b. (Middle) D.
c. (Last) STODDARD
235

4. DATE OF DEATH (Month) (Day) (Year) July 11, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Sept. 16, 1885
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Friend, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Chase — BIRTHPLACE Milledgeville, Illinois
14. MOTHER'S MAIDEN NAME Helen Acker — BIRTHPLACE Genive Lake, Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 518-05-5824
17. INFORMANT'S OWN SIGNATURE Katherine Ostrom — ADDRESS 703 Michael Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/23/65 *19*__, *to* 7/11/67, *19*__, *that I last saw the deceased alive on* 7/10/67 *19*__, *and that death occurred at* 11:45 P.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE Rex Borry M.D. — 054 (Degree or title)
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 8/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE July 14'67
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery
24d. LOCATION (City, town, or county) Boise — (State) Idaho

DATE REC'D BY LOCAL REG. 8-30-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Lowell Semaray
LICENSE NO. E-509

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Coroners

RECEIVED AUG 16 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3274
Local Reg. No. 431
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1515 Grove 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1515 Grove

3. NAME OF DECEASED (Type or Print)
a. (First) PATRICK
b. (Middle)
c. (Last) VORNEY

4. DATE OF DEATH (Month) 8 (Day) 1 (Year) 67

5. SEX Male
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown 0
8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Unknown
12. CITIZEN OF WHAT COUNTRY? Canada

13. FATHER'S NAME Unknown — BIRTHPLACE
14. MOTHER'S MAIDEN NAME X Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY No. 519-16-6583
17. INFORMANT'S OWN SIGNATURE David G. Volpintesta — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Mins;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Found dead, nude, on floor of his one room cabin. had been dead 7 days. — 7 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive *19___, to _____, 19___, that I last saw the deceased alive on _____ 19___, and that death occurred at* IIP *m., from the causes and on the date stated above.*

23a. SIGNATURE E. D. Paris 583 (Degree or title) Coroner
23b. ADDRESS 4 3720 Meadow Drive, Boise
23c. DATE SIGNED 8-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE August 11, 1967
24c. NAME OF CEMETERY OR CREMATORY Syringa Gardens
24d. LOCATION (City, town, or county) Boise (Ada) (State) Idaho

DATE REC'D BY LOCAL REG. 8-15-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Conway Grant — Conway Grant
LICENSE NO. E 478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY, Boise, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3275
Local Reg. No. 113
Reg. Dist. No. 371

BIRTH NO.

RECEIVED Bureau of Vital Statistics STATE OF IDAHO AUG 7 - 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE, IDAHO
c. LENGTH OF STAY (In this place): 67 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO. b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 412 Ada Street: Boise, Idaho.
d. STREET ADDRESS (If rural, give location): 412 Ada Street: Boise, Idaho.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Frederick	L	FITZGERALD.	8	1	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	6-12-15	52				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Business Rep. Plumber's
10b. KIND OF BUSINESS OR INDUSTRY: Union. Same.
11. BIRTHPLACE (State or foreign country): Texas.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: I. Burrett Fitzgerald — BIRTHPLACE: Texas.
14. MOTHER'S MAIDEN NAME: Florence Wilkinson. — BIRTHPLACE: Texas.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 455 01 1806
17. INFORMANT'S OWN SIGNATURE AND ADDRESS: VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Carcinoma with multiple metastases — INTERVAL BETWEEN ONSET AND DEATH: 1 Year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I last attended the deceased from 5-26-67, 19__, to 8-1, 19 67, and that death occurred at 7:22AM m., from the causes and on the date stated above.

23a. SIGNATURE, (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D. 597	VA Center, Boise, Idaho	8-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/3/67	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-7-67	Myrtle Palmer	Earl Waggoner	E-422

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG - 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 27 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3276
Local Reg. No. 117
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH — AUG 1 0 1967
a. COUNTY: ADA 01 308
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VET. ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: A IDAHO
b. COUNTY: VALLEY 430
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): COUNCIL
d. STREET ADDRESS (If rural, give location): Box 232

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	IRA	V	MARTIN		AUG	2,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	2-5-91	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Building	Verdsella, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William J Martin	Tenn.	Catherine Blalock	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	518 07 50 61	VA RECORDS	VA CENTER, BOISE

5271

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Emphysema, Chronic, pulmonary, ostrructive — INTERVAL BETWEEN ONSET AND DEATH: 3 Years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Hypoproteinemia — Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I attended the deceased from July 25, 19 67, to Aug. 2, 19 67, and that death occurred at 10:40 P m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, MD	597	VAC, BOISE, IDAHO	8-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-5-67	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-8-67	Myrtle Palmer		E-810

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3277
Local Reg. No. ~~XXX~~ 428
Reg. Dist. No. ~~XXXXXX~~ 370

Certificate of Death

RECEIVED
AUG 1 1 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 ADA 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 370 Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale -Rural
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First): Martha
b. (Middle): Louise
c. (Last): GARRITY

4. DATE OF DEATH (Month) (Day) (Year): August 2, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 27, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Phillipsburg Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred Buntrock — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 44 4317
17. INFORMANT'S OWN SIGNATURE: John Walter Garrity — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/28, 1967, *to* 8/2, 1967, *that I last saw the deceased alive on* 8/2, 1967, *and that death occurred at* 2:36P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 654 (Degree or title) M.D.
23b. ADDRESS: 425 W Bannock, Boise
23c. DATE SIGNED: 8/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE REC'D BY LOCAL REG.: Aug. 10, 1967
REGISTRAR'S SIGNATURE: Myrtle Palmer — Mrs. Martina Walmsley
25. EMBALMER: [signature]
LICENSE NO.: E-496
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Baker 121 E. Ida

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3278
Local Reg. No. 430
Reg. Dist. No. 270

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011 b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 7035 Hummel Drive

3. NAME OF DECEASED (Type or Print): a. (First) EMMA b. (Middle) ERICKSON c. (Last) BERARDINELLI

4. DATE OF DEATH: (Month) 8 (Day) 3 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 26, 1902

9. AGE (In years last birthday): 65 IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Denver, Colorado

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louie or Ludwig Erickson BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Stenakisa Unknown BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 543-20-3027

17. INFORMANT'S OWN SIGNATURE: X Louise Roberts ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 023X Thrombosed iliac artery — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Luetic Aortitis + Vasculitis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Acute rheumatoid Arthritis — 14 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* May, 1963 *to* Aug, 1967, *that I last saw the deceased alive on* July 31, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: George R Baker MD (Degree or title)
23b. ADDRESS: 121 E. Idaho Boise
23c. DATE SIGNED: 8-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal
24b. DATE: 8-4-67
24c. NAME OF CEMETERY OR CREMATORY: Clackamas
24d. LOCATION (City, town, or county) (State): Clackamas, Oregon

DATE REC'D BY LOCAL REG.: 8-15-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
EMBALMER: Conway Grant
LICENSE NO.: E478
FIRM NAME: Kelyea Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

4208 Bannock
Formerly 208 Kirtley
RECEIVED
FEB. Blvd.

Certificate of Death

STATE OF IDAHO

State File No. 3279
Local Reg. No. 223
Reg. Dist. No. 370

BIRTH NO.

AUG 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 01 | c. LENGTH OF STAY (in this place): 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho | b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1720 North 26th

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	EARL	AUGUSTA	BAKER		8	3	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	1 - 9 - 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cooper, Texas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Taylor Baker — BIRTHPLACE: Alabama
14. MOTHER'S MAIDEN NAME: Bertie Jordan — BIRTHPLACE: Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 446-09-5009
17. INFORMANT'S OWN SIGNATURE: + Miranda L Baker — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ASCVD (Coronary occlusion) — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/3, 1967, *to* 8/3, 1967, *that I last saw the deceased alive on* DOA, 19__, *and that death occurred at* 10½ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Mark W. Stewart, MD (Degree or title)
23b. ADDRESS: 2621 Madison Ave
23c. DATE SIGNED: 8/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/7/1967
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 8-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478
FIRM NAME: Relyea Mortuary, Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician I happened to be in the ER when he was brought in DOA!

Certificate of Death

STATE OF IDAHO

State File No. 3280
Local Reg. No. 434
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 11 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 01 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2713 Ona St.

3. NAME OF DECEASED (Type or Print): a. (First) Terrance; b. (Middle) Patrick; c. (Last) Morris

4. DATE OF DEATH: (Month) August (Day) 3 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Feb. 11, 1964

9. AGE (In years last birthday): 3
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant at home 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Bob R. Morris — BIRTHPLACE: Caldwell, Idaho

14. MOTHER'S MAIDEN NAME: Nila Lair — BIRTHPLACE: Buroak, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: 2713 Ona Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9290

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by drowning. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Fell into an open cesspool in their yard about 6 ft Deep. — second

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 01

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19, *to* , 19, *that I last saw the deceased alive on* , 19, *and that death occurred at* 7 IOP *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title): Coroner

23b. ADDRESS: 3720 Meadow Drive, Boise.

23c. DATE SIGNED: 8-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 7, 1967

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-10-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature] LICENSE NO.: E-483

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 25 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3281
Local Reg. No. 114
Reg. Dist. No. 371

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 01 ADA — AUG 8 - 1967 — 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (in this place) 25 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VET ADMINISTRATION CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 38 OREGON
b. COUNTY 333 BAKER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BAKER
d. STREET ADDRESS (If rural, give location) 2783 - 1st Street

3. NAME OF DECEASED (Type or Print)
a. (First) KEITH
b. (Middle) H
c. (Last) ATTEBERRY

4. DATE OF DEATH (Month) (Day) (Year) AUG 3, 1967

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3

8. DATE OF BIRTH 7-19-24

9. AGE (In years last birthday) 43
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 10

10b. KIND OF BUSINESS OR INDUSTRY RAILROAD

11. BIRTHPLACE (State or foreign country) BAKER, OREGON

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME HERBERT ATTEBERRY
BIRTHPLACE MISSOURI

14. MOTHER'S MAIDEN NAME NORA GILKISON
BIRTHPLACE IDAHO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES
(If yes, give war or dates of service) WW II

16. SOCIAL SECURITY NO. 540 28 1734

17. INFORMANT'S OWN SIGNATURE VA SRECORDS
ADDRESS BOIE, IDAHO

18. CAUSE OF DEATH 4344
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Idiopathic cardiomegaly
INTERVAL BETWEEN ONSET AND DEATH: 12 Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I attended the deceased from July 8, 1967, to Aug. 3, 1967, that I last saw the deceased alive on [illegible] and that death occurred at 1:10 P m., from the causes and on the date stated above.

23a. SIGNATURE M.G. STROMBERG, M.D. 597 (Degree or title)

23b. ADDRESS VAC, BOISE, IDAHO

23c. DATE SIGNED 8-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 8/4/67

24c. NAME OF CEMETERY OR CREMATORY North Powder Cem.

24d. LOCATION (City, town, or county) (State) North Powder, Oregon

DATE REC'D BY LOCAL REG. 8-7-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Earl Waggoner
LICENSE NO. E-422
FIRM NAME McBrathey-Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated; and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3282
Local Reg. No. 124
Reg. Dist. No. 371

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Nursing Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 020
b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Ellis
b. (Middle): B.
c. (Last): Snow

4. DATE OF DEATH (Month) 8 (Day) 5 (Year) 1967

5. SEX: male
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: 10/11/1882
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: ranching
11. BIRTHPLACE (State or foreign country): Indian Valley, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ellis B. Snow — BIRTHPLACE: Vermont
14. MOTHER'S MAIDEN NAME: Matilda Sorenson — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-42-2119A
17. INFORMANT'S OWN SIGNATURE: Florence S. Lyke — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Cataracts

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1949, *to* Aug 5, 1967, *that I last saw the deceased alive on* Aug 5, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 510
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 8/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 8/7/67
24c. NAME OF CEMETERY OR CREMATORY: Indian Valley Cemetery
24d. LOCATION (City, town, or county): Indian Valley Adams (State): Idaho

DATE REC'D BY LOCAL REG.: 8-28-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E 464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 4 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 13 1986

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 14 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3283
Local Reg. No. 236
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Union 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): LaGrande
d. STREET ADDRESS (If rural, give location): Route #1, Box 103

3. NAME OF DECEASED (Type or Print): a. (First) Bernard; b. (Middle); c. (Last) Cain

4. DATE OF DEATH: (Month) Aug. (Day) 5 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Sept. 27, 1897	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Lewistown, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Patrick Cain — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 498-36-6335
17. INFORMANT'S OWN SIGNATURE: Elizabeth Cain — ADDRESS: Route 1 Box 133 LaGrande, Oreg.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8-2-67
19b. MAJOR FINDINGS OF OPERATION: Enlarged prostate - benign
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1964, *to* Aug 5, 1967 *that I last saw the deceased alive on* Aug 5, 1967 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: H B Jeppesen 259 (Degree or title) MD
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 8/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-11-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Howell V. Summers
LICENSE NO.: E 509
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3284
Local Reg. No. 220
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN Boise
LENGTH OF STAY (in this place) 1 Year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 316 W. Washington

3. NAME OF DECEASED (Type or Print) a. (First) James b. (Middle) ------ c. (Last) Soukup
4. DATE OF DEATH (Month) (Day) (Year) Aug. 5, 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 15, 1877
9. AGE (In years last birthday) 90 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Frt. Dept. C.B. and Q.
10b. KIND OF BUSINESS OR INDUSTRY 08 Mail Room
11. BIRTHPLACE (State or foreign country) Lincoln, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Soukup BIRTHPLACE Checkoslavakia
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Checkoslavakia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 707-07-1065
17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Mont.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 mos
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) Paralyzed arteriosclerosis — 2 years
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis Heart Disease — 2 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1948, 19__ to Aug 5, 1967, that I last saw the deceased alive on Aug 4, 1967, and that death occurred at 2 P.M., from the causes and on the date stated above.

23a. SIGNATURE [signature] (Degree or title) MD
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED 8/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-8-67
24c. NAME OF CEMETERY OR CREMATORY Cloverdale
24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. 8-8-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-400
FIRM NAME: Gibson Funeral Home 342-8821

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 8 - 1967

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3285
Local Reg. No. 423
Reg. Dist. No. 370

RECEIVED AUG 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3806 Grover St.

3. NAME OF DECEASED (Type or Print) a. (First) Milton b. (Middle) L. c. (Last) Points

4. DATE OF DEATH (Month) 8 (Day) 6 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Mar. 5, 1892

9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles L. Points BIRTHPLACE Kansas

14. MOTHER'S MAIDEN NAME Martha Henshaw BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-10-3221 A

17. INFORMANT'S OWN SIGNATURE X Laima Points ADDRESS Boise

18. CAUSE OF DEATH 4500
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mesenteric Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 DAYS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 8-5-67

19b. MAJOR FINDINGS OF OPERATION Mesenteric Thrombosis

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23, 1962, *to* 8-6, 1967, *that I last saw the deceased alive on* 8-6, 19 67, *and that death occurred at* 5:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE D.O. Grover Rees 510 (Degree or title) 1

23b. ADDRESS

23c. DATE SIGNED 8 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8-9-1967

24c. NAME OF CEMETERY OR CREMATORY Terrace Lawn Cemetery

24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 8-8-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Eldon T. Pearson LICENSE NO. E-512

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 20 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

cc Johnson

Certificate of Death

STATE OF IDAHO

State File No. 3286
Local Reg. No. 447
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 308
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 8 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Nursing Home 282

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 200 Homestead Dr.
d. STREET ADDRESS (If rural, give location): Boise, Idaho

3. NAME OF DECEASED (Type or Print): Mrs. PAULA (a. First) ELIZABETH (b. Middle) HANSEN (c. Last)

4. DATE OF DEATH: (Month) 8 (Day) 6 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 1/31/1906

9. AGE (In years last birthday): 61
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Elgin, Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Slotwin
BIRTHPLACE: Austria

14. MOTHER'S MAIDEN NAME: Frances Kottoun
BIRTHPLACE: Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Victor E. Hansen
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 151 Metastatic carcinoma — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of the stomach — 4 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7/19, 19 67, *to* 8/6, 19 67, *that I last saw the deceased alive on* 8/5/67, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE C. C. JOHNSON, M.D (Degree or title) — C. C. Johnson 8/6/67
23b. ADDRESS: Boise 425 West Bannock Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/9/1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant — Conway Grant
LICENSE NO.: E-478
FIRM NAME: RELYEA MORTUARY, Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 28 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Coroner

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3287
Local Reg. No. 427
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 011 — AUG 15 1967 — 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho — Bureau of Vital Statistics — c. LENGTH OF STAY (In this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1722 South Latah 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 011 — b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho

d. STREET ADDRESS (If rural, give location): 1722 South Latah

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	CLIFFORD	WILLIAM	TREBILCOCK		8	6	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 4	August 24, 1890	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04		Manley, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Trebelcock			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
WW # 1	3	519-01-5883	Mrs. Clara B. Trebelcock	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Had bad stomach trouble.had to eat soft, and liquid foods.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____ *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. D. Rees	583 Coroner 4	3720 Meadow Drive, Boise.	8-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 11, 1967	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-15-67	Myrtle Palmer	Conway Grant Conway Grant	E478

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: RELYEA MORTUARY, Boise, Idaho

AUG 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3288
Local Reg. No. 432
Reg. Dist. No. 370

RECEIVED AUG 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 201
b. CITY OR TOWN: Boise
LENGTH OF STAY (in this place): 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 9203 Overland Road

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) W. c. (Last) Phillips

4. DATE OF DEATH: (Month) Aug. (Day) 7 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 17, 1872
9. AGE (In years last birthday): 95 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Finland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ------ BIRTHPLACE: Finland
14. MOTHER'S MAIDEN NAME: ------ BIRTHPLACE: Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-60-3951
17. INFORMANT'S OWN SIGNATURE: Wendy E. Phillips ADDRESS: 9203 Overland Road Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stroke — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

334X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/20, 1967, *to* 8/7, 1967, *that I last saw the deceased alive on* 8/6, 1967, *and that death occurred at* 8:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] MD (Degree or title)
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 8/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 8-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Fred C. Wilkins LICENSE NO. E 483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3289
Local Reg. No. 437
Reg. Dist. No. 370

RECEIVED AUG 14 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 01 Ada
b. CITY OR TOWN: Boise
LENGTH OF STAY (in this place): 2½ Years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 01 Ada
c. CITY OR TOWN: Boise
d. STREET ADDRESS (If rural, give location): 108 Warm Springs Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	BERTHA	OTTE	MARTIN	Aug. 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	April 10, 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Otte	Switzerland	Jane S. Tull	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO. 518-54-0557
17. INFORMANT'S OWN SIGNATURE: Eulene [illegible] Lane ADDRESS: 920 Warm Springs Boise, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 20 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral arteriosclerosis with partial right Hemiparesis Senility — 2½ Months

4200

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/5, 1948, *to* 8/8, 1967, *that I last saw the deceased alive on* 7/23, 1967, *and that death occurred at* 1:12A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 421 M		Boise	8/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-10-67	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-11-67	Myrtle Palmer	[signature]	E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3290
Local Reg. No. 136
Reg. Dist. No. 371

BIRTH NO.

AUG 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada. 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) VA Center, Boise Idaho
c. LENGTH OF STAY (In this place) 29 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho.
d. STREET ADDRESS (If rural, give location) 2505 Redway Circle.

3. NAME OF DECEASED (Type or Print) a. (First) Floyd b. (Middle) Clifford c. (Last) TATE.

4. DATE OF DEATH (Month) 8 (Day) 8 (Year) 67

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 8-23-30

9. AGE (In years last birthday) 36 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 18 Special Agent. Treasury Dept: Same

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME John C Tate. BIRTHPLACE Oklahoma

14. MOTHER'S MAIDEN NAME Lila Wyman. BIRTHPLACE Colo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) POKO

16. SOCIAL SECURITY NO. 519 28 5964

17. INFORMANT'S OWN SIGNATURE John D Tate ADDRESS VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Perforating ulcer gastro-esophageal junction. — 6 Weeks

DUE TO (c) Islet cell carcinoma of pancreas. — Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 6-29-67

19b. MAJOR FINDINGS OF OPERATION Perforating ulcer at gastro-esophageal junction.

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-10, 19 67, to 8-8, 19 67, that I last saw the deceased alive, and that death occurred at 11:15 AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) R. J. BUNGARD, M.D. — 23b. ADDRESS VA Center, Boise, Idaho. — 23c. DATE SIGNED 8-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE 8/12/67 — 24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery — 24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 8-18-67 — REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Russell A. Kelly — LICENSE NO. E-412

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 27 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3291
Local Reg. No. 465
Reg. Dist. No. 370

Certificate of Death

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 441
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 336 W. Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): Leona
b. (Middle): Isabel
c. (Last): Cummings

4. DATE OF DEATH (Month) 8 (Day) 8 (Year) 1967

5. SEX: female
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: 10/4/1903
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Rocky Ford, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ollie D. Norris — BIRTHPLACE: ------
14. MOTHER'S MAIDEN NAME: Erie Craford — BIRTHPLACE: ------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: X Carrol K. Cummings — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1718 Melanotic Carcinoma Cervix — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Dorsal Spinal Paralysis — 4 wks

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 393 (Degree or title)
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 8-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 8/14/67
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: 8-25-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E 388
FIRM NAME: Northam Jones Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 3 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3292
Local Reg. No. 434
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 16 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 011 Ada 302

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (in this place): 2 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 011

b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 3921 Collister Drive

3. NAME OF DECEASED (Type or Print)

a. (First): THOMAS

b. (Middle): F.

c. (Last): HOWE

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 28, 1892

9. AGE (In years last birthday): 75

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Business Agent (Ret) 26

10b. KIND OF BUSINESS OR INDUSTRY: Engineers

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: No record

BIRTHPLACE: No record

14. MOTHER'S MAIDEN NAME: No record

BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes

(If yes, give war or dates of service): WW #1 3

16. SOCIAL SECURITY NO.: 536-03-0118

17. INFORMANT'S OWN SIGNATURE: Phyllis F. Howe ADDRESS: 3921 Collister Dr. Boise, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the lung — INTERVAL BETWEEN ONSET AND DEATH: 18 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Probable cerebral metastases — 3 mo

19a. DATE OF OPERATION: 28 Apr 67

19b. MAJOR FINDINGS OF OPERATION: Metastatic carcinoma of lymph node of neck

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 May, 1966, *to* 9 Aug, 1967, *that I last saw the deceased alive on* 9 Aug, 1967, *and that death occurred at* 5:45 PM, *from the causes and on the date stated above.*

23a. SIGNATURE: Clayton C. Morgan 370 (Degree or title): M.D.

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 11 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-12-67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-16-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Russell Ramsay LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 16 1967

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

6- 14.9

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3293
Local Reg. No. 433
Reg. Dist. No. 370

RECE AUG 16 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 01 b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 300 O'Farrell Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PHYLLIS	DAE	CODLING	Aug. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Aug. 13, 1927	39				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	At home	Ogden, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Leigh Huggins	South Dakota	Alice Larsen	Portland, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No ---	529-30-6709	Robert H Codling	300 O'Farrell Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 410X Mitral valvular disease — INTERVAL BETWEEN ONSET AND DEATH (??) yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rheumatic heart disease (??) yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic nephritis (??) yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-7, 1967, *to* 8-9, 1967, *that I last saw the deceased alive on* 8-9, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Paul F Miner -364 MD	105 N. 8th Street Boise Idaho	8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-14-67	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-16-67	Myrtle Palmer	F. Richard Reed	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR - 5 1991

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3294
Local Reg. No. 449
Reg. Dist. No. 370

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

AUG 22 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1016 East Boise Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): ELBERT
b. (Middle):
c. (Last): CAIN

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 11, 1885
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY: Cain Sales Co.
11. BIRTHPLACE (State or foreign country): Elizabethtown, Kentucky
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Laurel P. Cain — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Emma Hare — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 464-28-5863
17. INFORMANT'S OWN SIGNATURE: Adeline Cain — ADDRESS: 1016 E. Boise, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4331

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Atrial & Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 3 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteria sclerosis — 10 yr
DUE TO (c): Left hemiplegia — 6 Months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Urinary tract infection — 2 Months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1957, 19__, *to* 8-9-67, 19__, *that I last saw the deceased alive on* 8-9-67, 19__, *and that death occurred at* 5:28 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. D. Springer 491 MD
23b. ADDRESS: 220 N. 1st Boise Ida
23c. DATE SIGNED: 8-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-12-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-18-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Howell D. Demaray — LICENSE NO. E-509
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Kiefer

Certificate of Death

STATE OF IDAHO

State File No. 3295
Local Reg. No. 485
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 5 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print) a. (First) Emerson b. (Middle) Roy c. (Last) Jackson

4. DATE OF DEATH (Month) (Day) (Year) August 9, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH May 1, 1913
9. AGE (In years last birthday) 54 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Civil service 08
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Dennison, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jackson BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Jennie Wright BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY 286-09-3348
17. INFORMANT'S OWN SIGNATURE Ruth V. Pont ADDRESS Gooding, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Head injury c Transection of spinal cord C-1.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Terminal pneumonia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) /
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm
21c. (CITY, TOWN, OR TOWNSHIP) Gooding (COUNTY) (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-6-67 5:00 p.m.
21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? Rolled over by a tractor

22. *I hereby certify that I attended the deceased from* 8-6-67, 19__, *to* 8-9-67, 19__, *that I last saw the deceased alive on* 8-9-67, 19__, *and that death occurred at* 1:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.
23b. ADDRESS 616 Eastman Bldg. Twin
23c. DATE SIGNED 9-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-15-1967
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) (State) Gooding--Gooding, Idaho

DATE REC'D BY LOCAL REG. 9-5-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Dale McMurtrey LICENSE NO. E-410
FIRM NAME: Summers Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service
Form DH-630

Helen Olson

DUTIES: SEP 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3296
Local Reg. No. 478
Reg. Dist. No. 370

RECEIVED AUG 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 34 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 001 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1012 Sherman Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ADA	M.	SANDERS	Aug. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	June 28, 1911	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Office Clerk 08	Br. of Reclamation	Alva, Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Ross	Oklahoma	Lucy J. (Unknown)	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	519-46-9228	Ada Sanders	1012 Sherman Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Probable primary: Breast
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-3- , 19 67, *to* 8-10 , 19 67 *that I last saw the deceased alive on* 8-10 , 19 67, *and that death occurred at* 2:00 AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 447 W. Rose MD
23b. ADDRESS 6003 Overland Boise
23c. DATE SIGNED 8-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-12-67
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 8-21-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Howell W. Summers
LICENSE NO. E-509
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

15

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3297
Local Reg. No. 778
Reg. Dist. No. 371

RECEIVED AUG 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): 55 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho. 160
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
d. STREET ADDRESS (If rural, give location): Box 151.

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): D
c. (Last): PRICE.

4. DATE OF DEATH (Month) (Day) (Year): 8 10 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Separated 4
8. DATE OF BIRTH: 5-9-46
9. AGE (In years last birthday): 21 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: James C Price — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Fern O Shupe — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): POKC 7
16. SOCIAL SECURITY NO.: 536 44 5269
17. INFORMANT'S OWN SIGNATURE: John D. Stark — ADDRESS: VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

224X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Thymoma — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that I~~ attended the deceased from 6-16, 19 67, to 8-10, 19 67, ~~that I last saw the deceased alive on~~ and that death occurred at 3:12AM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): M. G. STROMBERG, M.D. 597
23b. ADDRESS: VA Center, Boise, Idaho
23c. DATE SIGNED: 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 8-11-67
24c. NAME OF CEMETERY OR CREMATORY: Ogden Cemetery
24d. LOCATION (City, town, or county) (State): Ogden, Utah

DATE REC'D BY LOCAL REG.: 8-15-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

SEP 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 7 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 25 1985

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3298
Local Reg. No. 119
Reg. Dist. No. 371

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

AUG 16 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: 011 Ada 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 011

b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 3115 Sycamore Drive

3. NAME OF DECEASED (Type or Print)

a. (First): Martin

b. (Middle):

c. (Last): Kassner

4. DATE OF DEATH (Month) (Day) (Year): August 11, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Feb. 7, 1890

9. AGE (In years last birthday): 77

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bldg.-Contractor 11

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Michigan

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME BIRTHPLACE

14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes

(If yes, give war or dates of service): W.W. 1 3

16. SOCIAL SECURITY NO.: 566-18-0778

17. INFORMANT'S OWN SIGNATURE: x Patricia M. Cavaille

ADDRESS: 148 4th St. Sonoma Calif.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral & Generalized Arteriosclerosis progressive

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-11, 1967, *to* 12-6, 1966, *that I last saw the deceased alive on* 12-6, 1966, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 318 M.D.

23b. ADDRESS: 401 N. Orchard Boise Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/15/67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-16-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: A. E. Alden

LICENSE NO.: 299

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McBratney-Alden-Waggoner

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 16 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3299
Local Reg. No. 466
Reg. Dist. No. 290

BIRTH NO.

RECEIVED STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 011 ADA — AUG 30 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 14
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOLL	JOHN	ANDERSON	August 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	infant 1	August 9, 1967	0	0	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
------- 02		Boise Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Byron Verde Anderson	Richfield, Utah	Sonya Joll	New Haven, Connecticut

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
------		--------	Byron V Anderson	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7735

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Respiratory distress syndrome — INTERVAL BETWEEN ONSET AND DEATH: from birth

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Prematurity

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Birth 8/9, 19 67, *to* 8/11, 19 67, *that I last saw the deceased alive on* 8/11, 19 67, *and that death occurred at* 1:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Stan Myers III 384 MD	200 E Bannock Boise	8/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, Town, or county) (State)
Aug. 14, 1967	Aug. 14, 1967	Hillcrest Cemetery	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-67	Myrtle Palmer	Richard W. Mesenbrink	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3300
Local Reg. No. #35
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 16 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN Boise
c. LENGTH OF STAY (in this place) 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Alphonsus Hospital 008

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 112½ East Idaho Street

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) CATHERINE c. (Last) RING

4. DATE OF DEATH (Month) (Day) (Year) August 11, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) never married

8. DATE OF BIRTH Oct. 2, 1884

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) secretary

10b. KIND OF BUSINESS OR INDUSTRY 19 Swift & Co.

11. BIRTHPLACE (State or foreign country) Des Moines, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Ring
BIRTHPLACE Canada

14. MOTHER'S MAIDEN NAME Mary Sautter
BIRTHPLACE Albany, New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 505-01-2659

17. INFORMANT'S OWN SIGNATURE Lily Ring Brownell
ADDRESS Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cerebral Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Coronary Arteriosclerosis

332X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 11, 1967, to Aug 7, 1967, that I last saw the deceased alive on Aug 7, 1967, and that death occurred at 5:25 p.m., from the causes and on the date stated above.

23a. SIGNATURE C C Johnson (Degree or title) M.D.

23b. ADDRESS Boise Ida

23c. DATE SIGNED 8-15-'67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal/burial

24b. DATE 8-14-67

24c. NAME OF CEMETERY OR CREMATORY Mary Magdalene Cemetery

24d. LOCATION (City, town, or county) (State) Omaha, Nebraska

DATE REC'D BY LOCAL REG. 8-16-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Lowell L. Summers

LICENSE NO. E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 16 1967

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Robert Holdren

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3301
Local Reg. No. 445
Reg. Dist. No. 370

BIRTH NO.

AUG 18 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 30 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)
a. (First): Chauncey
b. (Middle):
c. (Last): Draper

4. DATE OF DEATH (Month) (Day) (Year): August 11, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): unknown
8. DATE OF BIRTH: June 29, 1910
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Utah, Wellington
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Melvin Draper — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Ella Nora White — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Ted Draper by Conway Grant — ADDRESS: Orem, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Oat Cell Bronchogenic CA — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Rt Lung
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Robert Holdren 236 (Degree or title) M.D. 1
23b. ADDRESS: 201 W State St
23c. DATE SIGNED: 15 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: August 12, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sandy Cemetery
24d. LOCATION (City, town, or county) (State): Sandy, Utah

DATE REC'D BY LOCAL REG.: 8-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Relyea Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 22 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3302
Local Reg. No. 736
Reg. Dist. No. 370

RECEIVED AUG 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 19 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 011 Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2015 Nez Perce Street

3. NAME OF DECEASED (Type or Print)
a. (First): HALFORD
b. (Middle): CLYDE 003
c. (Last): DRAPER

4. DATE OF DEATH: (Month) (Day) (Year): Aug. 12, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 11, 1890

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer-Retired 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Schuyler, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Cassius W. Draper
BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Hester Frazier
BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 507-01-0982

17. INFORMANT'S OWN SIGNATURE: Aura L. Draper
ADDRESS: 2015 Nez Perce Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Cancer of Liver ✓ & lymph nodes — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Primary Cancer of Pancreas — About 8 mo
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Aortic Aneurysm

19a. DATE OF OPERATION: 8/3/67
19b. MAJOR FINDINGS OF OPERATION: Liver & Nodes - Extensive Carcinomatosis Primary Ca of Pancreas

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/27, 1967, *to* 8/12, 1967, *that I last saw the deceased alive on* 8/12, 1967, *and that death occurred at* 4:05 PM *from the causes and on the date stated above.*

23a. SIGNATURE: Everett R. Jones (Degree or title) MD
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 8/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-15-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: A. Dale McMasters
LICENSE NO.: E-410
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Chapman
148 E. Jefferson

Certificate of Death

STATE OF IDAHO

State File No. 3303
Local Reg. No. 454
Reg. Dist. No. 370

BIRTH NO. 67-7248 RL

343-4281

AUG 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1915 N. 11th. St.

3. NAME OF DECEASED (Type or Print)
a. (First): Lexy
b. (Middle): Dawn 003
c. (Last): Aucoin

4. DATE OF DEATH: (Month) August (Day) 12 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Aug. 12, 1967
9. AGE (In years last birthday): 0
If UNDER 1 YEAR: Months 0 Days 0
If UNDER 24 HRS.: Hours Min. 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None------Child 02
10b. KIND OF BUSINESS OR INDUSTRY: ---------
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joe L. Aucoin
BIRTHPLACE: Dallas, Texas
14. MOTHER'S MAIDEN NAME: LaVerne L. Shaw
BIRTHPLACE: Council, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): -
(If yes, give war or dates of service): -
16. SOCIAL SECURITY NO.: -
17. INFORMANT'S OWN SIGNATURE: Joe L Aucoin
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Intrauterine anoxia — INTERVAL BETWEEN ONSET AND DEATH: Less than 1°

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Aspiration of meconium. — 11
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Neonatal Pneumonia.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug 12, 1967, *to* Aug 12, 1967, *that I last saw the deceased alive on* Aug 12, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James C. Chapman, MD 089 1
23b. ADDRESS: 148 E Jefferson St. Boise
23c. DATE SIGNED: Aug 22, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/14/67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-22-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Paul Waggoner
LICENSE NO.: E-422
FIRM NAME: McBratney-Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3304
Local Reg. No. 437
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Luke's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2815 W. Jefferson

3. NAME OF DECEASED (Type or Print)
a. (First): Glenn
b. (Middle): Iver 002
c. (Last): Burrows

4. DATE OF DEATH: August 12, 1967 (Month) (Day) (Year)

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Oct. 12, 1914

9. AGE (In years last birthday): 52
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lake City, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Burrows
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Laura Sapp
BIRTHPLACE: Omaha, Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-01-2128

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: x Mrs Esther Burrows

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Myocardial Infarction.
INTERVAL BETWEEN ONSET AND DEATH: ± 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3/17, 1965, *to* 8/12, 1967, *that I last saw the deceased alive on* 6/1, 1967, *and that death occurred at* 3:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: O. E. Alden, M.D. 045 (Degree or title)
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/15/67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: O. E. Alden
LICENSE NO.: 299

FIRM NAME: McBratney-Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 1 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 2 6 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 1 3 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 5 1987

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3305
Local Reg. No. 125
Reg. Dist. No. 371

Certificate of Death

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 ADA 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 36 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 44
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WEISER
d. STREET ADDRESS (If rural, give location): 46 E. Galloway

3. NAME OF DECEASED (Type or Print)
a. (First): LINCOLN
b. (Middle): M 004
c. (Last): ERHARDT

4. DATE OF DEATH (Month) 8 (Day) 13 (Year) 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 9-16-79
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired painter 21
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Morris W. Erhardt — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Anna Milner — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): SAW
16. SOCIAL SECURITY NO.: 518 40 4359
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: VA HospitalRecords, Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

464X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary emboli. — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Thrombophlebitis. — 5 weeks
DUE TO (c): Arteriosclerotic heart disease. — Unknown

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ I attended the deceased from 7-8, 1967, to 8-13, 1967, ~~[illegible]~~ ~~alive on 19~~, and that death occurred at 12:10P m., from the causes and on the date stated above.

23a. SIGNATURE: O.F. SWINDELL, M.D. [signature] 597 (Degree or title)
23b. ADDRESS: VA Center, Boise, Idaho
23c. DATE SIGNED: 8-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 8/18/1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county): Weiser (State): Idaho

DATE REC'D BY LOCAL REG.: 8/28/67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: R. Dee Thomason
LICENSE NO.: E-388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3306
Local Reg. No. 462
Reg. Dist. No. 370

RECEIVED AUG 28 1967

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 011 Ada — 101

b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Boise — Bureau of Vital Statistics — LENGTH OF STAY (in this place): 11 Months

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 011 — b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 1607 Warm Springs Avenue

3. NAME OF DECEASED (Type or Print): a. (First) EDNA — b. (Middle) PEARL — c. (Last) TRUE

4. DATE OF DEATH (Month) (Day) (Year): Aug. 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Aug. 26, 1882	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dept. Mgr. 26	The Mode, Ltd.	Nashville, Illinois	USA

13. FATHER'S NAME: William Riley Harris, Nashville, — BIRTHPLACE: Ill

14. MOTHER'S MAIDEN NAME: Laura Ellen Rountree — BIRTHPLACE: No records

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 519-24-5087

17. INFORMANT'S OWN SIGNATURE: Helen Anne Compton — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

330X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Bronchopneumonia	1 wk
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Parkinsons Disease	1 yr
DUE TO (c)	Cerebral Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Recent Fracture hip	1 mo

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 10, 1967, *to* July 24, 1967, *that I last saw the deceased alive on* July 24, 1967, *and that death occurred at* 9:16 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George R Baker, MD	1121 E. Idaho	8/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8-15-67		Lamar, Missouri

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-67	Myrtle Palmer	[signature]	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 2 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

Jarrell

ADDITIONAL REMARKS by Physician.....

State File No. 3307
Local Reg. No. 438
Reg. Dist. No. 370

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1303 Hays St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1303 Hays St.

3. NAME OF DECEASED (Type or Print)
a. (First) Martha
b. (Middle) Moritz
c. (Last) French

4. DATE OF DEATH (Month) (Day) (Year) August 13, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Sept. 22, 1893
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) St. Cloud, Minnesota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel Peerman — BIRTHPLACE Unk.
14. MOTHER'S MAIDEN NAME DeFord — BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Bella Mae Highley — ADDRESS R#2 Meridian

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 6 wks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Coronary heart disease — (??) years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Carcinoma of breast — 1½ years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-2, 1967, *to* 8-13, 1967, *that I last saw the deceased alive on* 8-10, 1967, *and that death occurred at* 11 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE Paul F. Miner 364 (Degree or title) MD 1
23b. ADDRESS 105 N. 8th St. Boise Idaho
23c. DATE SIGNED 8/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/17/67
24c. NAME OF CEMETERY OR CREMATORY Pioneer Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 8-16-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER A. E. Alden — LICENSE NO. 299

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME McBratney-Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3308
Local Reg. No. 450
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place) 43 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 200 Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mayfield
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) GROVER b. (Middle) c. (Last) CORDER

4. DATE OF DEATH (Month) (Day) (Year) Aug. 13, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Aug. 12, 1884
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Mayfield, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Obediah Corder BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Anna (Unknown) BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE + Mark of Corder ADDRESS Mayfield, Idaho

18. CAUSE OF DEATH 4500
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c) Pulmonary Embolism

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/26, 1967, *to* 8/13, 1967, *that I last saw the deceased alive on* 8/13, 1967, *and that death occurred at* 4 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 306 (Degree or title)
23b. ADDRESS Boise, Ida.
23c. DATE SIGNED 8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-16-67
24c. NAME OF CEMETERY OR CREMATORY Pioneer Cemetery
24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. 8-18-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER LICENSE NO. E-410
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3309
Local Reg. No. 451
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 22 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 309
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 9 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 011 Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1629 Cleveland Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): HAZEL
b. (Middle): PEARL
c. (Last): POND

4. DATE OF DEATH (Month) (Day) (Year): Aug. 13, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 1
8. DATE OF BIRTH: June 4, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Caney, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Washington Betts — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Nellie Cornelia Connelly — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 519-22-5146
17. INFORMANT'S OWN SIGNATURE: Kenneth P. Pond — ADDRESS: 7525 Settlers Road, Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

491X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation c

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) pulmonary edema c
DUE TO (c) broncho pneumonia

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* osteoporosis c dislocation

INTERVAL BETWEEN ONSET AND DEATH: 10 days; 2 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: of lumbar vertebrae
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 8-12-67, 19__, *that I last saw the deceased alive on* 8-12-67, 19__, *and that death occurred at* 1:30 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. S. Springer MD 491 1
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 8-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-15-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-18-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: J. Richard Reed
LICENSE NO.: E-440

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 1 3 1996

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3310
Local Reg. No. 439
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1104 N. 23rd. St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1104 N. 23rd. St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Verene	Tindall	Pauley	Aug. 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Apr. 12, 1896	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Same	Boulder, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William B. Tindall	Illinois	Minnie Ripley	Eagle Rock, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-22-5396	William B. Pauley	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Probable acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct, 66, *to* 8-13, 67, *that I last saw the deceased alive on* 8-10, 1967, *and that death occurred at* 11P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. D. Young	773 MD	425 Bannock Boise	8-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/16/67	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-16-67	Myrtle Palmer	A. E. Alden	299

FIRM NAME: McBratney-Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED.. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3311.
Local Reg. No. 121
Reg. Dist. No. 371

RECEIVED AUG 1 8 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 ADA — 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 011 ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 709 Hale

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM	H	COLLISTER	8	13	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	5-29-98	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired painter 27
10b. KIND OF BUSINESS OR INDUSTRY: same
11. BIRTHPLACE (State or foreign country): Minneapolis, Kansas
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Robert D. Collister — BIRTHPLACE: Michigan
14. MOTHER'S MAIDEN NAME: Alice Chappel — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWI
16. SOCIAL SECURITY NO.: 519 03 5892
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: VA Hospital Records, Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease. — 9 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ I attended the deceased from 8-13, 19 67, to 8-13, 19 67, ~~that I last saw the deceased alive on~~, and that death occurred at 11:00 AM, from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
F. B. HINE, M.D. [signature]	597	VA Center, Boise, Idaho	8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
burial	Aug. 17 '67	Dry Creek Cemetery	Boise,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-18-67	Myrtle Palmer	[signature]	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 23 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3312
Local Reg. No. 453
Reg. Dist. No. 370

RECE

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-08
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: 555 Baker
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Baker
d. STREET ADDRESS (If rural, give location): 1305 Campbell

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): EVERETT
c. (Last): PRICE

4. DATE OF DEATH (Month) (Day) (Year): August 13, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced 4
8. DATE OF BIRTH: May 12, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): butcher, retired 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: no record — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 540-12-5277
17. INFORMANT'S OWN SIGNATURE: 365 W. Adams ADDRESS: Burns, Ore.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Basilar Artery Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Acute Myocardial Infarction — 10 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/7, 1967, *to* 13 Aug, 1967, *that I last saw the deceased alive on* 13 Aug, 1967, *and that death occurred at* 7:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 654 [signature] MD.
23b. ADDRESS: 425 W Bannock, Boise, Ida
23c. DATE SIGNED: 8/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: Aug. 17 '67
24c. NAME OF CEMETERY OR CREMATORY: Portland Memorial
24d. LOCATION (City, town, or county): Portland (State): Oregon

DATE REC'D BY LOCAL REG.: 8-21-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-410

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Summers Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3313
Local Reg. No. 467
Reg. Dist. No. 370

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY in this place: 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1212 Happy Drive

3. NAME OF DECEASED (Type or Print): a. (First) ALLENE b. (Middle) B. c. (Last) ROLFE

4. DATE OF DEATH: (Month) (Day) (Year) Aug. 14, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Feb. 8, 1910

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 57

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert G. Brockbank, BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME: Jennie May Hughes, BIRTHPLACE Spanish Fork, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No ---

16. SOCIAL SECURITY NO.: 569-40-7849

17. INFORMANT'S OWN SIGNATURE: Paul Rolfe ADDRESS: 1212 Happy Drive, Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3½ Day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease — several yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Hypertension — 20 yrs -

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 11, 1967, *to* Aug 14, 1967, *that I last saw the deceased alive on* Aug 14, 1967, *and that death occurred at* 1:20 PM *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner MD (Degree or title) 364

23b. ADDRESS: 105 N. 8th St Boise, Idaho

23c. DATE SIGNED: 8/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Entombment

24b. DATE: 8-16-67

24c. NAME OF CEMETERY OR CREMATORY: Mtn View Mausoleum

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-28-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Dale McMurtrey — LICENSE NO.: E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3314
Local Reg. No. 452
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 22 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place) 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011 b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 7001 Brentwood

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JERRY	LOU	GOODWIN	August 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never married 7	Oct. 20, 1942	24				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary-Merit System 19
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Kenneth L. Goodwin BIRTHPLACE Boise, Idaho
14. MOTHER'S MAIDEN NAME Helen Agnes Canfield BIRTHPLACE Rockland, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-48-2469
17. INFORMANT'S OWN SIGNATURE Kenneth L Goodwin 7001 Brentwood ADDRESS Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

201X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hodgkins Sarcoma — INTERVAL BETWEEN ONSET AND DEATH 6 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1963, *to* Aug 14, 1967, *that I last saw the deceased alive on* Aug 14, 1967, *and that death occurred at* 10:25P m., *from the causes and on the date stated above.*

23a. SIGNATURE C C Johnson 261 (Degree or title) MD
23b. ADDRESS Boise Ida
23c. DATE SIGNED 8-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/17/67
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. 8-21-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Chas E Wacker
LICENSE NO. E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Clohessy

344-4441

Certificate of Death

State File No. 3315
Local Reg. No. 446
Reg. Dist. No. 370

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 01 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 04
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print): a. (First) Lloyd; b. (Middle) VERNON; c. (Last) BURCHAM

4. DATE OF DEATH: (Month) 8 (Day) 14 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: 11/18/1909

9. AGE (In years last birthday): 57
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Benton County Arkansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Wesley Burcham
BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Eunice Williams
BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-05-7103

17. INFORMANT'S OWN SIGNATURE: X Mrs Bill Walker
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: approx 36 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Pulmonary emphysema.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/9, 1967 *to* 8/14, 1967, *that I last saw the deceased alive on* 8/14, 1967, *and that death occurred at* 12 45 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Clohessy, M.D. 095

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 8/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/18/67

24c. NAME OF CEMETERY OR CREMATORY: Roswell Cemetery

24d. LOCATION (City, town, or county) (State): Roswell, Idaho

DATE REC'D BY LOCAL REG.: 8-18-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant

LICENSE NO.: E478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

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(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

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STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Clayton Morgan

Certificate of Death

STATE OF IDAHO

State File No. 3316
Local Reg. No. 122
Reg. Dist. No. 371

RECEIVED AUG 22 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route # 5, Boise, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
d. STREET ADDRESS (If rural, give location) Route # 5

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM		LUNSTRUM	8	15	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 11, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Marshalltown, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME J Peter K. Lunstrum — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Caroline Malin — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE W. P. Lunstrum — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2017 Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH 10 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of prostate — 3 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 30 Mar, 1965, *to* 15 Aug, 1967, *that I last saw the deceased alive on* 17 Aug, 1967, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Clayton O. Morgan 370	M.D.	Boise, Idaho	17 Aug 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/17/67	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-18-67	Myrtle Palmer	Conway Grant Conway Grant	E-178

FIRM NAME: RELYEA MORTUARY, BOISE, IDAHO

Federal Security Agency
United States Public Health Service
Form DH-63021

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DUTIES:

SEP 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

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STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-7258
BIRTH NO.

RECF

Certificate of Death

STATE OF IDAHO

AUG 25 1967

Bureau of Vital Statistics

State File No. 3317
Local Reg. No. 457
Reg. Dist. No. 370

1. PLACE OF DEATH

a. COUNTY 011 Ada 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 011 b. COUNTY Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise

d. STREET ADDRESS (If rural, give location) 6955 Hummel

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Christine	Elizabeth	McCarley	Aug. 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	Aug. 15, 1967				4	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child 02	Child	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George McCarley	Nevada	Edna McCarley	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	No.	George McCarley	Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7760

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Prematurity J — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) none

DUE TO (c) none

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/15, 19__, *to* 8/16, 19__, *that I last saw the deceased alive on* 8/16, 19__, *and that death occurred at* 4:35 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Alan Myers III 384	MD	200 E. Bannock	8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-18-67	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-24-67	Myrtle Palmer	Daniel G. Gibson Daniel G. Gibson	E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

John T Swartley
1703 Hill Rd

Certificate of Death

STATE OF IDAHO

State File No. 3318
Local Reg. No. 2479
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 6 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN: Boise
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Saint Lukes 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN: Boise
d. STREET ADDRESS (If rural, give location): 1802 No. 32nd

3. NAME OF DECEASED (Type or Print): a. (First) MARY b. (Middle) c. (Last) PLOTT

4. DATE OF DEATH: (Month) 8 (Day) 17 (Year) 67

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Sept. 2, 1889

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer 22

10b. KIND OF BUSINESS OR INDUSTRY: Grocery Store

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-14-3606

17. INFORMANT'S OWN SIGNATURE: Lenn Johnson
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Breast — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pagets Disease —
DUE TO (c) Multiple Metastasis — 5 mo

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/3/66, 19__, *to* 8/17/67, 19__, *that I last saw the deceased alive on* 8/17/66, 19__, *and that death occurred at* 6:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: 1703 Hill Road, Boise
23c. DATE SIGNED: 8/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/19/67
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 8-30-67
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Funeral
LICENSE NO.: E478

FIRM NAME: RELYEA CHAPEL-Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Poindexter
Eastman Building
342-3621

RECEIVED
SEP 8 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3319
Local Reg. No. 494
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 011 Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1111 North 8th.

3. NAME OF DECEASED (Type or Print)
a. (First): Grace
b. (Middle): Sorenson
c. (Last): Bringman

4. DATE OF DEATH (Month) (Day) (Year): Aug. 17, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 23, 1891
9. AGE (In years last birthday): ~~74~~ 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Resturant 23
10b. KIND OF BUSINESS OR INDUSTRY: Owner
11. BIRTHPLACE (State or foreign country): Mayfield, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Mads Peter Sorenson — BIRTHPLACE: U.S.A.
14. MOTHER'S MAIDEN NAME: Josephine Carlson — BIRTHPLACE: U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Genevieve M. Goodwin — ADDRESS: Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4/6X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 11 dys.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Rheumatic Heart Disease — ?

DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: —

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 2/1, 1966, *to* 8/17, 1967, *that I last saw the deceased alive on* 8/17, 1967, *and that death occurred at* 3:50 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 42 (Degree or title)
23b. ADDRESS: Boise
23c. DATE SIGNED: 8/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 8-19-67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-7-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512
FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021 Helen Olson

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 25 1967 Bureau of Vital

Certificate of Death

STATE OF IDAHO

State File No. 3320
Local Reg. No. 455
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 720 Richmond 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 720 Richmond

3. NAME OF DECEASED (Type or Print): a. (First) Dell b. (Middle) Daniel c. (Last) Madden

4. DATE OF DEATH (Month) (Day) (Year): Aug. 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 20, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician 09
10b. KIND OF BUSINESS OR INDUSTRY: Idaho Power Co.
11. BIRTHPLACE (State or foreign country): Meridian, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles E. Madden — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Cora J. Ellison — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-01-0206
17. INFORMANT'S OWN SIGNATURE: Al Dodd — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis — unkn.
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Lymphosarcoma — 2 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1963, *to* 8-17, 1967, *that I last saw the deceased alive on* 7-25, 1967, *and that death occurred at* 8:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wm D Forney 173 (Degree or title) M.D.
23b. ADDRESS: 425 Bannock Boise
23c. DATE SIGNED: 8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-21-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 8-23-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jearead
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3321
Local Reg. No. 468
Reg. Dist. No. 370

Certificate of Death

RECEIVED AUG 30 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 240 Idaho
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Maggie
b. (Middle): Mary
c. (Last): Vipperman

4. DATE OF DEATH (Month) (Day) (Year): August 17, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 15, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Ellendale, Virginia
12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: William Wilson — BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Rachael Mariah Spence — BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE from Thompson Chapel records — ADDRESS: Robert Meyer

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Digitalis intoxication — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-17, 1967, *to* _____, 19__, *that I last saw the deceased alive on* 8-17, 1967, *and that death occurred at* 3:30 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: M Jones, 268 M (Degree or title)
23b. ADDRESS: Boise
23c. DATE SIGNED: 8-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-21-67
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding Gooding Co. Idaho

DATE REC'D BY LOCAL REG.: 8-28-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Lowell D Demaray
LICENSE NO.: E 509

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Summers Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3322
Local Reg. No. 459
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian Rural
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) Nancy b. (Middle) V. c. (Last) Teeter

4. DATE OF DEATH (Month) (Day) (Year) Aug. 18, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Aug. 13, 1889

9. AGE (In years last birthday) 78
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Dodge City, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Melvin Davidson
BIRTHPLACE Virginia

14. MOTHER'S MAIDEN NAME Lucy Colliggs
BIRTHPLACE Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs. M. J. Voorhees
ADDRESS Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1750 bowel obstruction — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma Ovary — unk

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1967, *to* death, 19___, *that I last saw the deceased alive on* 18 Aug, 1967, *and that death occurred at* 4:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE Lee L. Pulley 624 (Degree or title) MD

23b. ADDRESS 925 E 1st Meridian Ida

23c. DATE SIGNED 21 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8-22-67

24c. NAME OF CEMETERY OR CREMATORY Meridian Cemetery

24d. LOCATION (City, town, or county) Meridian, Idaho (State)

DATE REC'D BY LOCAL REG. 8-25-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Leo Jensen

LICENSE NO. E-266

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 17 1975

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3323
Local Reg. No. 447
Reg. Dist. No. 370

RECEIVED AUG 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1904 North 28th.

3. NAME OF DECEASED (Type or Print)
a. (First): Lillian
b. (Middle): T.
c. (Last): Cook

4. DATE OF DEATH (Month) (Day) (Year): Aug. 18, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 4, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Carrollton, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Tuley — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Mary Ennis — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-16-6317
17. INFORMANT'S OWN SIGNATURE: X Joseph T. Cook — ADDRESS: FAIRFIELD IDAHO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Adeno-Carcinoma of the Colon

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: metasis to brain

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Adeno-Carcinoma of Colon & liver
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-11, 19 65, *to* 8-18-, 19 67, *that I last saw the deceased alive on* 8-18-, 19 67, *and that death occurred at* 5 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Jos. M. Thomas 528 [illegible]
23b. ADDRESS: 305 Fort St. Boise, Idaho
23c. DATE SIGNED: 8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-22-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-21-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAY 22 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 04 2000

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3324
Local Reg. No. 476
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 001 — SEP 1 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: 555 Contra Costa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Martinez
d. STREET ADDRESS (If rural, give location): 1330 Vine Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Horace b. (Middle) Cate c. (Last) Fowler

4. DATE OF DEATH: (Month) (Day) (Year): August 19, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 5, 1898

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months 4 Days 14
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Nampa, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Fowler — BIRTHPLACE: Tenn.

14. MOTHER'S MAIDEN NAME: Lou Ava Cate — BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 546-09-5044

17. INFORMANT'S OWN SIGNATURE & ADDRESS: Nina B. Fowler

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 331X Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis — (?) yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Coronary heart disease — 14 yrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-16, 1967, *to* 8-19, 1967, *that I last saw the deceased alive on* 8-18, 1967, *and that death occurred at* 2:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner 3604 (Degree or title) M.D.

23b. ADDRESS: 105 N. 8th St. Boise, Idaho

23c. DATE SIGNED: 8/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Aug. 21, 1967

24c. NAME OF CEMETERY OR CREMATORY: Nitch, Sunset View Cemetery

24d. LOCATION (City, town, or county) (State): Berkley, California

DATE REC'D BY LOCAL REG.: 8-31-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Merville D Davis — LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RE[illegible]

Certificate of Death

STATE OF IDAHO

State File No. 3325
Local Reg. No. 456
Reg. Dist. No. 370

BIRTH NO. AUG 25 1967

1. PLACE OF DEATH
a. COUNTY 011 Ada Bureau of Vital Statistics 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1 Nite
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) Columbia Hotel

3. NAME OF DECEASED (Type or Print)
a. (First) Nick
b. (Middle) -----
c. (Last) Corak

4. DATE OF DEATH (Month) (Day) (Year) Aug. 19, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Dec. 11, 1882
9. AGE (In years last birthday) 84 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Yugoslavia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown — BIRTHPLACE Yugoslavia
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Yugoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-07-5845-A
17. INFORMANT'S OWN SIGNATURE Frank J. Unesti — ADDRESS Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5705

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Not known — INTERVAL BETWEEN ONSET AND DEATH —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Bowel Obstruction —
DUE TO (c) Possible Coronary Occlusion

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 19, 1967, *to* only, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Robert M. Frazier, M.D. (Degree or title) 176
23b. ADDRESS Boise, Idaho.
23c. DATE SIGNED Aug. 23, 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-22-67
24c. NAME OF CEMETERY OR CREMATORY Morris Hill
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 8-23-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Eldon T. Pearson — Eldon T. Pearson
LICENSE NO. E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECE

Certificate of Death

STATE OF IDAHO

State File No. 3326
Local Reg. No. 458
Reg. Dist. No. 370

BIRTH NO. AUG 25 1967

1. PLACE OF DEATH
a. COUNTY 011 Bureau of Vital Statistics 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1042 Clover Drive

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) Thomas
c. (Last) Hailey

4. DATE OF DEATH (Month) Aug. (Day) 20, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 4, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): City Park Com. 08
10b. KIND OF BUSINESS OR INDUSTRY: City
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jess. C. Hailey — BIRTHPLACE: Oregon
14. MOTHER'S MAIDEN NAME: Annie C. Taylor — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-10-4804
17. INFORMANT'S OWN SIGNATURE: Jessie Brown — ADDRESS: Fallon, Nevada

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Heart Disease — 12 yrs
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Enlarged prostate — 3 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5, 1961, *to* Aug-20, 1967, *that I last saw the deceased alive on* Aug 20, 1967, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Carl B. Smithson 484 (Degree or title) MD
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 8-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-23-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-24-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — LICENSE NO. E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3327
Local Reg. No. 133
Reg. Dist. No. 371

RECEIVED AUG 28 1967 Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) BOISE, IDAHO
c. LENGTH OF STAY (in this place) One Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 080 IDAHO
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Garden Valley
d. STREET ADDRESS (If rural, give location) Garden Valley

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bradley	L	POSTON	8	20	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	2-24-93	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Rancher 04	Same	Virginia.	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Boston	Virginia	Cora Spears.	Virginia.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE
Yes	WW I 3 332X	519-10-3722	VA Hospital Records, Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis of cerebral artery. — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I, the undersigned, attended the deceased from 8-19, 19 67 to 8-20, 19 67 [illegible] and that death occurred at 9:20 AM, from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D. 597 (Degree or title)	VA Center, Boise, Idaho	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-24-67	Horse Shoe Bend	Horse Shoe Bend, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-23-67	Myrtle Palmer	Eldon T. Pearson	E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

File

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 8 1967 Bureau of Vital Statistics

State File No. 3328
Local Reg. No. 135
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 ADA 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 240 Idaho
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman
d. STREET ADDRESS (If rural, give location): RT # 1

3. NAME OF DECEASED (Type or Print)
a. (First): Clayton
b. (Middle): J
c. (Last): ROBERTSON

4. DATE OF DEATH (Month) (Day) (Year): 8 20 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 8-19-94
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Trapper 04
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Calvin Robertson. Oregon.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Clara Hunt. Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 519 01 04 03
17. INFORMANT'S OWN SIGNATURE — ADDRESS: VA Hospital Records, Boise, Idaho. John D. Stark

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction. — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that I~~ attended the deceased from 8-16, 1967, to 8-20, 1967, ~~that I last saw the deceased~~ ~~alive on~~ ~~19~~ and that death occurred at 5:30PM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): 592 H. G. STROMBERG, M.D. Fred B. Hing MD
23b. ADDRESS: VA Center, Boise, Idaho.
23c. DATE SIGNED: 8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hagerman Cem
24d. LOCATION (City, town, or county) (State): Idaho Gooding County

DATE REC'D BY LOCAL REG.: 9-7-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478

Federal Security Agency
United States Public Health Service
Form DH-63025 By Helen Olson
FIRM NAME: Kelyea Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 26 1991

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2329
Local Reg. No. 2279
Reg. Dist. No. 370

RECEIVED
AUG 28 1967

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 01 Ada 310

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau

c. LENGTH OF STAY in this place: 10 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: 01 Idaho b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 1105 Federal Way

3. NAME OF DECEASED (Type or Print): a. (First) SAMUEL b. (Middle) JAMES c. (Last) BRADFORD

4. DATE OF DEATH (Month) (Day) (Year): Aug. 20, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Feb. 12, 1898

9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner-Operator 21

10b. KIND OF BUSINESS OR INDUSTRY: Star Lite Motel

11. BIRTHPLACE (State or foreign country): Bellevue, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hugh Bradford — BIRTHPLACE: Belfort, Ireland

14. MOTHER'S MAIDEN NAME: Elizabeth Wallace — BIRTHPLACE: Iola, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-44-5400

17. INFORMANT'S OWN SIGNATURE: Bernice Bradford ADDRESS: 968 Lincoln Twin Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5932 Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Chronic Glomerulonephritis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1963, *to* Aug 20, 1967, *that I last saw the deceased alive on* Aug 20, 1967 *and that death occurred at* 10:30 PM *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 335 (Degree or title)

23b. ADDRESS: 1808 La Cassia Dr. Burley

23c. DATE SIGNED: Aug 23 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-23-67

24c. NAME OF CEMETERY OR CREMATORY:

24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: 8-28-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Orval E Walker LICENSE NO.: E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3330
Local Reg. No. 488
Reg. Dist. No. 370

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 8 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Oregon 38
b. COUNTY Malheur 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser, Idaho
d. STREET ADDRESS (If rural, give location) Rt. 3, Oregon Slope

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE
b. (Middle)
c. (Last) DEINES

4. DATE OF DEATH (Month) 8 (Day) 21 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 11/10/1912
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Lincoln, Nebraska
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME William Deines — BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME ---- — BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Edna Deines — ADDRESS Weiser

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

6000

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) ureteral stone & — ?
DUE TO (c) pyelonephritis - rt. — 1 yr - ?

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION 8-19-67
19b. MAJOR FINDINGS OF OPERATION ureteral stone & pyelonephritis
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 16, 1967, *to* death, 19__, *that I last saw the deceased alive on* 8-21, 1967 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE RB Jeppesen 254 (Degree or title) MD
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 8/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 8/25/1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. 9-5-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Marshall Dickerson Jr
LICENSE NO. E-464

Federal Security Agency
United States Public Health Service
Form DH-63022 Helen Olson
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3331
Local Reg. No. 226
Reg. Dist. No. 371

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 310
b. CITY OR TOWN Boise, Idaho.
LENGTH OF STAY (in this place) 10 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 140 Idaho. b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wilder
d. STREET ADDRESS (If rural, give location) Box 383

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Alfonso	L	SARCEDA.	8	21	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Filipino.	Divorced 4	5-2-00	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Laborer 06	Same	Phillipine Islands	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Patricia Sarceda	P.I.	Florencia Layos.	P.I.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II	536 01 66 66		VA Hospital Records, Boise, Idaho.

4200

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease with congestive heart failure. — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Essential hypertension. — 7 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. ~~I hereby certify that I~~ attended the deceased from 8-11, 19 67, to 8-21, 19 67, ~~that I last saw the deceased alive on~~ and that death occurred at 6:25 AM m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. F. SWINDELL, M.D.	597	VA Center, Boise, Idaho	8-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 24, 67	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-67	Myrtle Palmer	Leonard C. Flaniff	E-481

FIRM NAME: Homedale's Flaniff Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 21 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3332
Local Reg. No. 482
Reg. Dist. No. 370

BIRTH NO.

SEP 6 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 10days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 01 Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 918 O'Farrell St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Frances	E.	Hedges	Aug. 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed 2	March 31, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher 12	Boise Schools	Canton, South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Archie Clark	Wisconsin	Inez Relton	Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-48-5856	John Hedges	195 Chesterfield Place Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

20.01

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Extensive metastatic malignancy — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Lympho sarcoma
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-12, 1967, *to* 8-22, 1967, *that I last saw the deceased alive on* 8-22, 1967, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C C Johnson	261 MD	Boise Idaho	8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
ENTOMBMENT	8/25/67	Mt'n. View Mausoleum	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-31-67	Myrtle Palmer	Willard L. Maw	E-443

Federal Security Agency
United States Public Health Service

Form DH-63021

MOUNTAIN VIEW FUNERAL HOME, BOISE, IDA.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 26 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 26 197

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3333
Local Reg. No. 469
Reg. Dist. No. 370

Certificate of Death

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township place): Boise
c. LENGTH OF STAY (If not in place): 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 011 Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)
a. (First): TECKLA
b. (Middle): J.
c. (Last): PETERSON

4. DATE OF DEATH (Month) (Day) (Year): Aug. 22, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 24, 1885
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Alingsos, Sweden
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Johanos Pearson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 519-28-3551
17. INFORMANT'S OWN SIGNATURE: Oscar D. Peterson — ADDRESS: Route #1 Boise, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

6371

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Gastro urinary infection — 10 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Senile dementia — 2 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1946, *to* 8-22, 1967, *that I last saw the deceased alive on* 8-20, 1967, *and that death occurred at* 5:30 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Rowmark M.D. 319
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-25-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-28-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Lowell D. Demaray
LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 0 9 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

343-428

State File No. 3336
Local Reg. No. 464
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 011 Ada — AUG 30 1967 — Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise

c. LENGTH OF STAY (In this place) 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE 011 Idaho — b. COUNTY Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise

d. STREET ADDRESS (If rural, give location) 1816 Penninger Circle

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edward	Joseph	Schiedel	Aug. 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Jan. 18, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Building	Youngstown, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Steven Edward Schiedel	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S (OWN SIGNATURE)	ADDRESS
No		519-01-4514	Jesse L. Schiedel by Fee	Boise, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis

DUE TO (c) Pulmonary Emphysema

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5-9-, 1967, *to* 5-14-, 1967, *that I last saw the deceased alive on* 8-22-, 1967, *and that death occurred at* 7:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
393	Boise, Idaho	8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/26/67	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-67	Myrtle Palmer		E-460

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3335
Local Reg. No. 470
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
AUG 30 1967
Bur. of Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. St Lukes Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 016
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise - Rural
d. STREET ADDRESS (If rural, give location): R# 1

3. NAME OF DECEASED (Type or Print): a. (First) HAROLD b. (Middle) L. c. (Last) TULLER

4. DATE OF DEATH: (Month) August (Day) 22, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec.5, 1913

9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Humiston Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Tuller — BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Floris Pease — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 524 16 1576

17. INFORMANT'S OWN SIGNATURE: Ruth Tuller — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Heart Disease — years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1958, 19__, *to* Aug 22, 1967, *that I last saw the deceased alive on* July, 1967, *and that death occurred at* 9:25A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert M. Frazier, MD

23b. ADDRESS: 2010 N Gle - Boise

23c. DATE SIGNED: Aug 24, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 25, 1967

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: 8-28-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Richard W. Mesenbrink — LICENSE NO.: E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Hugh Atchley, Jr
401 Idaho

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3336
Local Reg. No. 473
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ~~Ada~~ 010 AUG 30 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise — Bureau of Vital Statistics — LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Center 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 077 b. COUNTY Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
d. STREET ADDRESS (If rural, give location) 808 N. Curtis Rd.

3. NAME OF DECEASED (Type or Print) a. (First) PEARL b. (Middle) HURST c. (Last) DAISWELL

4. DATE OF DEATH (Month) 8 (Day) 22 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	11/8/1880	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Derrick, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Pierre La Fontaine (Pierre LeFontain) — BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Eliza[illegible] Sattler — BIRTHPLACE Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Lynn Hurst — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 334 Arteriosclerotic cerebrovascular disease — INTERVAL BETWEEN ONSET AND DEATH 4 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture left hip and pyelonephritis — 1 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 26 June, 1967, *to* 22 Aug, 1967, *that I last saw the deceased alive on* 16 Aug, 1967, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE J Hugh Atchley Jr (Degree or title) MD
23b. ADDRESS 401 Idaho St Boise Ida
23c. DATE SIGNED 30 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/26/67
24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 8-30-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Conway Grant
LICENSE NO. E478

FIRM NAME: RELYEA MORTUARY-Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 30 1967

SEP 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Ward
2913 Cleveland

Certificate of Death

STATE OF IDAHO

343-4281

State File No. 3337
Local Reg. No. 460
Reg. Dist. No. 370

BIRTH NO.

RECEIVED

1. PLACE OF DEATH
a. COUNTY Ada 011 AUG 25 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Bureau of Vital Statistics
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Valley Sunset Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 011 Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3115 Sycamore Dr.

3. NAME OF DECEASED (Type or Print)
a. (First) Alpheus
b. (Middle) 235 Garfield
c. (Last) Lawrence

4. DATE OF DEATH (Month) (Day) (Year) Aug. 22, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 25, 1882
9. AGE (In years last birthday) 85 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer 04
10b. KIND OF BUSINESS OR INDUSTRY farming
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Lawrence — BIRTHPLACE New York, N.Y.
14. MOTHER'S MAIDEN NAME Almeda Markley — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 543-12-1255
17. INFORMANT'S OWN SIGNATURE X Marjorie Ruth Washburn — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

592X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Chronic nephritis — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 15, 1967, *to* Aug 22, 1967, *that I last saw the deceased alive on* Aug 22, 1967, *and that death occurred at* 4 40 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Roscoe C Ward MD 550 (Degree or title)
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 8/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 8/26/67
24c. NAME OF CEMETERY OR CREMATORY Greenwood Hill Cem.
24d. LOCATION (City, town, or county) (State) Portland, Oregon

DATE REC'D BY LOCAL REG. 8-25-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-460

Federal Security Agency
United States Public Health Service
Form DH-63022 Helen Olson
FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 25 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3338
Local Reg. No. 132
Reg. Dist. No. 371

RECEIVED
SEP 8 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 010 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 15 Mi. East on Inerstate 80 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 200
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
d. STREET ADDRESS (If rural, give location) 1220 Juniper Street

3. NAME OF DECEASED (Type or Print)
a. (First) GARY
b. (Middle) RAY
c. (Last) HARMON

4. DATE OF DEATH (Month) (Day) (Year) August 23, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married /
8. DATE OF BIRTH Feb. 9, 1949
9. AGE (In years last birthday) 18 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Wendell, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wayne Harmon — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Betty Brown — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-54-5526
17. INFORMANT'S OWN SIGNATURE X Wayne H. Harmon — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed skull & Brain Injury — INTERVAL BETWEEN ONSET AND DEATH Inst;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Lab Alcohol Test. C.I5.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident /
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 000 (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8 23 67 I250A m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto, One car roll over.

22. *I hereby certify that I attended the deceased from* Did Not See Alive *19*__, *to* Alive *19*__, *that I last saw the deceased alive on* ____, *19*__, *and that death occurred at* I250A *m., from the causes and on the date stated above.*

23a. SIGNATURE E. D. Paris 583 (Degree or title) Coroner 4
23b. ADDRESS 3720 Meadow Drive, Boise.
23c. DATE SIGNED 8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/26/67
24c. NAME OF CEMETERY OR CREMATORY Mtn. View Cemetery
24d. LOCATION (City, town, or county) Mountain Home, Idaho (State)

DATE REC'D BY LOCAL REG. 9-5-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER H. Weil Humphrey
LICENSE NO. E-502

Federal Security Agency
United States Public Health Service
Form DH-63021 Helen Olson FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 29 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-7271 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3339
Local Reg. No. 480
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada — SEP 6 1967 — 406
b. CITY OR TOWN Boise — Bureau of Vital Statistics — c. LENGTH OF STAY (in this place) 6 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011 — b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 2016 Crystal Way

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
William	Howard	Allred	Aug.	24,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Aug. 24, 1967				6	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02	None	Boise, Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Coral S. Allred	Idaho Falls, Ida.	Sally I. Griffin	Spokane, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Coral Stephen Allred	Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 776X Prematurity — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Birth Wt, # 7 1/2 oz — 5 hours
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 8-24, 1967, *to* 8-24, 1967, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
519 Sumnehut mD	200 E Bannock Boise	8-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 26, 1967	Valleyview Cemetery	Vale, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-30-67	Myrtle Palmer	Robert J. Bertelsen	Dre. 107

FIRM NAME: Bertelsen-Lienkaemper

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3340
Local Reg. No. 774
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 31 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 011 Ada 201

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (in this place): 1 Month

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho b. COUNTY: 01 Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 1615 Idaho Street

3. NAME OF DECEASED (Type or Print): a. (First) FRANK b. (Middle) A. 292 c. (Last) ROWE (SR)

4. DATE OF DEATH (Month) (Day) (Year): Aug. 24, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Feb. 17, 1884

9. AGE (In years last birthday): 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer 08

10b. KIND OF BUSINESS OR INDUSTRY: State Highway

11. BIRTHPLACE (State or foreign country): Indiana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Josiah Rowe BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Nora Benham BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-24-8003

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Frank A. Rowe Jr. 3805 North Boise, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral and cardiac arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Under

DUE TO (c) — INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Secondary, persistent urinary tract infection — INTERVAL BETWEEN ONSET AND DEATH: Unk

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-11, 1967, *to* 8-24, 1967, *that I last saw the deceased alive on* 8-10, 1967, *and that death occurred at* 2:10 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. D. FORNEY, M.D. — **23b. ADDRESS**: 425 W. Bannock, Boise — **23c. DATE SIGNED**: 8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Entombment — **24b. DATE**: 8-25-67 — **24c. NAME OF CEMETERY OR CREMATORY**: Mtn. View Memorial — **24d. LOCATION** (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-30-67 — **REGISTRAR'S SIGNATURE**: Myrtle Palmer

25. EMBALMER: J. Richard Reed — **LICENSE NO.**: E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 22 1967

JUN 24 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3341
Local Reg. No. 463
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Stat. Stats

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 603

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 011 Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print)
a. (First) GLENN
b. (Middle) DAWSON
c. (Last) ESTES

4. DATE OF DEATH (Month) (Day) (Year) Aug. 24, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 17, 1905
9. AGE (In years last birthday) 61 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager-Operator 26
10b. KIND OF BUSINESS OR INDUSTRY Service Station
11. BIRTHPLACE (State or foreign country) El Dorado Springs, Mo.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Walter Lee Estes — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Maude C. Jennings — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 537-05-2463
17. INFORMANT'S OWN SIGNATURE Mrs True Estes — ADDRESS Route #2 Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Brain injury

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Pneumonia — bilateral ?
DUE TO (c) Encephalomalacia + pneumonia

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* ~~[illegible]~~ Encephalo-malacia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Sub Dural hygroma ?
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 00
21c. (CITY, TOWN, OR TOWNSHIP) Boise 13 (COUNTY) 800 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 6-21-67 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Automobile Accident

22. *I hereby certify that I attended the deceased from* 6/21, 1967, *to* 8/25, 1967, *that I last saw the deceased alive on* 6/25/67, 19__, *and that death occurred at* 9:00 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 1381 (Degree or title)
23b. ADDRESS 616 Eastman Bldg.
23c. DATE SIGNED 8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-26-67
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 8-28-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Fred E. Walker — LICENSE NO. E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 6 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept 7, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3342
Local Reg. No. 474
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St.Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California
b. COUNTY: 05 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): San Diego
d. STREET ADDRESS (If rural, give location): 1627 Guy St.

3. NAME OF DECEASED (Type or Print): a. (First) GAIL; b. (Middle) LLOYD; c. (Last) HIGBEE

4. DATE OF DEATH: (Month) (Day) (Year): August 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: June 11, 1938
9. AGE (In years last birthday): 29 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Warehouse Foreman 24
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Drug
11. BIRTHPLACE (State or foreign country): Goddard, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lloyd Higbee — BIRTHPLACE: Goddard, Kansas
14. MOTHER'S MAIDEN NAME: Irene M. Pike — BIRTHPLACE: Woodard, Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 6-28-56- 6-27-60
16. SOCIAL SECURITY NO.: 510-36-4314
17. INFORMANT'S OWN SIGNATURE: Lloyd Higbee, 827 Woodlawn, Derby Ks — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Skull crushed. Brain Injury — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Broken back — Inst.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Auto accident

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 Boise (COUNTY) 011 Ada (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 25, 1967- 1A m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Automobile accident, Roll-over.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 930A m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris, Coroner 58-3 (Degree or title) 4
23b. ADDRESS: 3720 Meadow Drive, Boise
23c. DATE SIGNED: 8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 29, 1967
24c. NAME OF CEMETERY OR CREMATORY: Attica Cemetery
24d. LOCATION (City, town, or county) (State): Goddard, Kansas

DATE REC'D BY LOCAL REG.: 8-30-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E 478

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Relyea Mortuary, Boise, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH 9-5-67

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss.
County of Ada

Certificate No.

Date Filed Aug 30, 1967

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Gail Lloyd Higbee (Name on Original Certificate) who died (Was Born or Died) on Aug 25, 1967 (Date of Event)
in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by V.A. Papers (Bible Record, Insurance Policy, Etc.) prepared on August 31, 1967 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item # 8 Date of birth	June 11, 1932	June 11, 1938

Subscribed and sworn to before me this 5th day of September, 1967

Phyllis B. Grant

Notary Public, residing at Boise, Idaho

My commission expires March 1968

(Seal)

X Signed Russell A. Kelly Sr.
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 6th day of September, 19 67

Phyllis B. Grant

Notary Public, residing at Boise Idaho

My commission expires March, 1968

(Seal)

X Signed Conway Grant
(Signature of Any Credible Person)

(Street Address, City, State)

FORM DH 60-155

9-5-67

Aug 30, 1967

Aug 25, 1967

June 11, 1932

June 11, 1932

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 474
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada — AUG 30 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alph onsus, Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SanDiego
d. STREET ADDRESS (If rural, give location): 1627 Guy St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	GAIL	LLOYD	HIGBEE		8	25	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	June 11, 1932	29				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Warehouse Forman
10b. KIND OF BUSINESS OR INDUSTRY: Wholesale Drug
11. BIRTHPLACE (State or foreign country): Goddard, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lloyd Higbee — BIRTHPLACE: Goddard, Kansas
14. MOTHER'S MAIDEN NAME: Irene M. Pike — BIRTHPLACE: Woodard, Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes 6/28/56-6/27/60
16. SOCIAL SECURITY NO.: 510-36-4314
17. INFORMANT'S OWN SIGNATURE: X Lloyd Higbee — ADDRESS: 827 WOODLAWN DERBY KS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Skull Crushed. Brain Injury.
INTERVAL BETWEEN ONSET AND DEATH: 9 Hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Broken back.
Inst;

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Auto Accident.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Highway	Boise	Ada	Idaho

21d. TIME OF INJURY	(Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
	8	25	67	1:Am.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	Automobile Accident, Roll over.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 930A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Coroner	3720 Meadow Drive, Boise.	8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Aug. 29, 1967	Attica Cemetery	Goddard, Kansas	

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-30-67	Myrtle Palmer	[signature]	E478

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: REAVEA MORTUARY-Boise, Idaho

DUTIES:

AUG 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 6 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUN 7 1978

JUN 23 1978

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Coroner

Certificate of Death

STATE OF IDAHO

State File No. 3343
Local Reg. No. 127
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South of Highway 44 and 16 Junction

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) Route # 5, Box 276

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOANNE	ELAINE	MARSHALL	August 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Never Married	July 12, 1951	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) LaGrande, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Melvin V. Marshall	Wallowa, Oregon	Janet Cane	Pullman, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		None	x Melvin V Marshall	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8234

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed skull & Brain injury — INTERVAL BETWEEN ONSET AND DEATH: Inst;

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Automobile accident. — Inst;

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	06	13	001	

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
8	25	67	IA m.		One Car Accident. Roll over.

22. *I hereby certify that I attended the deceased from* Did Not to See Alive, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* I A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Parks	583 Coroner 4	3720 Meadow Drive, Boise.	8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/28/67	Bramblet Cemetery	Wallowa, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-30-67	Myrtle Palmer	Conway Shent	E 478

FIRM NAME: RELYEA MORTURAY, Boise, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

H Hatten
6003 Overland Rd

Certificate of Death

STATE OF IDAHO

State File No. 3344
Local Reg. No. 475
Reg. Dist. No. 370

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1717 Cleveland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
RALPH	LEWIS	WHITE	8	25	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	4/8/1907	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Worker 11
10b. KIND OF BUSINESS OR INDUSTRY: Iron Worker
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lewis White — BIRTHPLACE: Unknown USA
14. MOTHER'S MAIDEN NAME: [redacted] Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Merchant Marine
16. SOCIAL SECURITY NO.: 4200
17. INFORMANT'S OWN SIGNATURE: x Edna M White — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Pulmonary edema & ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASHD — ?
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 Aug, 1967, *to* 25 Aug, 1967, *that I last saw the deceased alive on* 25 Aug, 1967, *and that death occurred at* 6:20 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Hatten MD	6003 Overland, Boise Ida	30 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	8/28/67	Dry Creek Cemetery	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-30-67	Myrtle Palmer	Conway Grant	E-478

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: RELYEA MORTUARY, Boise, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 31 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3345
Local Reg. No. 48
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 8 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 4

3. NAME OF DECEASED (Type or Print): a. (First) Jerry; b. (Middle) K.; c. (Last) Douglass

4. DATE OF DEATH (Month) (Day) (Year): Aug. 26, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Aug. 2, 1944

9. AGE (In years last birthday): 23 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Kenneth I. Douglass
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Doris Tunnicliff
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-44-8754

17. INFORMANT'S OWN SIGNATURE: K. I. Douglass
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8254

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Edema — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Head injury
DUE TO (c) auto accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fractures radius, mandible, tibia & fibula, thorax

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Auto
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 28
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 080 (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: 9-5-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E-508
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 15 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3346
Local Reg. No. 496
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada
SEP 13 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 008

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 441
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	IRA	CLIFFORD	JACOBS		8	28	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	divorced 4	11/30/1895	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 21	Automobile	Edison, Nebraska	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Jacobs	----	Rebecca Epley	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		x Orval R. Manley	Weiser

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9030

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral anoxemia — INTERVAL BETWEEN ONSET AND DEATH: 48h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Pulmonary infarct — 3wks

DUE TO (c) postoperative embolic phenomenon — 3wks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Subtrochanteric fracture, femur — 3wks

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Above fracture	YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident 1	Home 01	Weiser 13	441	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
7	18	67	9p m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Fall at home

22. *I hereby certify that I attended the deceased from* 7-18-, 1967, *to* 8-28-, 1967, *that I last saw the deceased alive on* 8-28-, 1967, *and that death occurred at* 2:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ronald Albie	705 MD	Boise, Idaho	8/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
3 Removal-burial	8/31/67	Hillcrest Cemetery	Weiser	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-12-67	Myrtle Palmer	Marshall S. Dickerson Jr.	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 02 2015

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Hair 425 W Bannock

Certificate of Death

State File No. 3347
Local Reg. No. 788
Reg. Dist. No. 370

BIRTH NO.

RECEIVED

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 011 Ada — SEP 6 1967 — 000

b. CITY OR TOWN Boise — Bureau of Vital Statistics

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION Restful Manor Nursing Home 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 011 — b. COUNTY Ada

c. CITY OR TOWN Boise

d. STREET ADDRESS (If rural, give location) 815 East Jefferson

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	CALVIN	ROBERT	HENDERSON	8	28	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	September 4, 1895	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Teton City, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Oscar Henderson — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Isabelle MacKinlay — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: X Jack C. Henderson — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1992 Metastatic Carcinoma to Cerebellum, — INTERVAL BETWEEN ONSET AND DEATH: 14 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Lung and Mesentery

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1966, *to* Aug 28, 1967, *that I last saw the deceased alive on* Aug, 1967, *and that death occurred at* 9:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 654 (Degree or title) MD

23b. ADDRESS 425 W Bannock, Boise

23c. DATE SIGNED 8/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/31/67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 8-30-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant — LICENSE NO.: E478

FIRM NAME: RELYEA MORTUARY, Boise, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 12 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 6 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 8 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3348
Local Reg. No. 487
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 204
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 4 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 011 Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3214 Hamilton Street

3. NAME OF DECEASED (Type or Print)
a. (First) MAMIE
b. (Middle) F.
c. (Last) MORRISON

4. DATE OF DEATH (Month) (Day) (Year) Aug. 28, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 26, 1874
9. AGE (In years last birthday) 93 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY At home
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Warren Granger — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Louisa (Unknown) — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 518-60-6210
17. INFORMANT'S OWN SIGNATURE Everett Morrison — ADDRESS 7002 Brookover Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerosis Cerebral — 10-12 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1963, *to* Aug 27, 1967, *that I last saw the deceased alive on* 8-27, 1967, *and that death occurred at* 9:45 PM *from the causes and on the date stated above.*

23a. SIGNATURE James [illegible] 242 (Degree or title)
23b. ADDRESS 104 N. Latah
23c. DATE SIGNED 8/30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-31-67
24c. NAME OF CEMETERY OR CREMATORY Star, Cemetery
24d. LOCATION (City, town, or county) (State) Star, Idaho

DATE REC'D BY LOCAL REG. 9-5-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [illegible] — LICENSE NO. E-483

Federal Security Agency
United States Public Health Service
Form DH-63021 Helen Olson
FIRM NAME: SUMMERS FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

File

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3349
Local Reg. No. 134
Reg. Dist. No. 371

BIRTH NO.

SEP 7 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada. 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho.
c. LENGTH OF (If outside place) 29 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho. 011
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise,
d. STREET ADDRESS (If rural, give location) 36 Mesa Drive.

3. NAME OF DECEASED (Type or Print)
a. (First) Wayne
b. (Middle) C
c. (Last) COURSON.

4. DATE OF DEATH (Month) 8 (Day) 28 (Year) 67

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 2-5-97
9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Accountant. 19
10b. KIND OF BUSINESS OR INDUSTRY Same
11. BIRTHPLACE (State or foreign country) Iowa.
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Anthony W. Courson. BIRTHPLACE Pa.
14. MOTHER'S MAIDEN NAME Elizabeth Bahlman. BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1 3
16. SOCIAL SECURITY NO. 528077442.
17. INFORMANT'S OWN SIGNATURE John D. Stark ADDRESS VA Hospital Records, Boise, Idaho.

237X

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain tumor. — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that I~~ attended the deceased from 7-31, 1967, to 8-28, 1967, ~~that I last saw the deceased alive on 19~~ and that death occurred at 9:25PM m., from the causes and on the date stated above.

23a. SIGNATURE O. F. SWINDELL, M.D. (Degree or title) O. F. Swindell 597
23b. ADDRESS VA Center, Boise, Idaho.
23c. DATE SIGNED 8-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept 1 1967
24c. NAME OF CEMETERY OR CREMATORY Cloverdale
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 9-7-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Conway Prairie LICENSE NO. E478

Federal Security Agency
United States Public Health Service

Form DH-63091 Helen Olson FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

VA

DUTIES:

SEP 7 - 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 4 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 18 1981

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3350
Local Reg. No. 471
Reg. Dist. No. 370

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002 304

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: 011 Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3700 Mountain View Drive

3. NAME OF DECEASED (Type or Print): a. (First) Paul b. (Middle) V c. (Last) Christopher

4. DATE OF DEATH (Month) (Day) (Year): August 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	Dec. 13, 1903	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Linotype Operator
10b. KIND OF BUSINESS OR INDUSTRY: 27 Printing
11. BIRTHPLACE (State or foreign country): Fairfield, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: A.O. Christopher — BIRTHPLACE: Mudlake, Iowa
14. MOTHER'S MAIDEN NAME: Mary Kennedy — BIRTHPLACE: Parkerberg, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 530-01-2336
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4222

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Pulmonary emphysema several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-25, 1961, *to* 8-28, 1967, *that I last saw the deceased alive on* 8-28, 1967, *and that death occurred at* 10:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner MD (264) (Degree or title)
23b. ADDRESS: 105 N. 8th St Boise Idaho
23c. DATE SIGNED: 8/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/30/67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-29-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature] LICENSE NO.: E-460
FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Pr. Minor
Eastman Bu[illegible]

RECEIVED
SEP 6 1967
Bureau of Vital

Certificate of Death

STATE OF IDAHO

State File No. 3351
Local Reg. No. 483
Reg. Dist. No. 370

BIRTH NO. 3430028

1. PLACE OF DEATH
a. COUNTY 011 Ada 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 714 N. 8th

3. NAME OF DECEASED (Type or Print)
a. (First) Kathryn
b. (Middle) Machos
c. (Last) Giffin

4. DATE OF DEATH (Month) Aug. (Day) 28 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 20 1888
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Bryant Texas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert Machos — BIRTHPLACE: Poland
14. MOTHER'S MAIDEN NAME: Agnes Shook — BIRTHPLACE: Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 519-46-2207
17. INFORMANT'S OWN SIGNATURE: W. A. Giffin — ADDRESS: Boise

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — several hrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-10, 1961, *to* 8-28, 1967, *that I last saw the deceased alive on* 8-27, 1967, *and that death occurred at* 8:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner 364 MD. (Degree or title)
23b. ADDRESS: 105 N. 8th St. Boise, Idaho
23c. DATE SIGNED: 9-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 23 67
24c. NAME OF CEMETERY OR CREMATORY: St. John's
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-1-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Gibson Funeral Home — Daniel G. Gibson
LICENSE NO. 400

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Daniel Gibson

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 26 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3352
Local Reg. No. 493
Reg. Dist. No. 370

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada — SEP 8 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise — c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 41 — b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 412 E. Liberty

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	LEON	LEISHMAN	HILL	8	29	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	married 3	March 29, 1967	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck operator 22	Creamery	Wellsville, Utah	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Kerr Hill	----	Nettie Leishman	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		x Dulah K. Hill	Weiser, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

2040

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Chronic lymphatic Leukemia 15 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-22-, 19 67, *to* 8-29-, 19 67, *that I last saw the deceased alive on* 8-29-, 19 67, *and that death occurred at* 9:50 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	393	[illegible]	8/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial-Removal	9/2/1967	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-7-67	Myrtle Palmer by Helen Olson	Marshall S. Dickerson Jr.	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

SEP 20 1967

NOV 30 1967

DEC 1 1967

FEB 7 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3353
Local Reg. No. 129
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada.
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): 22 Days.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 011 Idaho.
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 2311 Palouse Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	John	W	PFAFF.	Aug. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Divorced. 4	8-10-02	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cab Driver. 06	Same	Ohio	USA.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Pfaff.	Austria.	Agnes Pauline.	Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 2	285 07 1811	John W Pfaff	VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of stomach/ — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
VA m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

~~I last attended~~ I attended the deceased from 3-7, 19 67, to 8-29, 19 67 ~~that I last saw the decedent~~ ~~alive on~~ ~~19~~ and that death occurred at 2:45 PM m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D.	541	VA Center, Boise, Idaho	8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-1-67	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-5-67	Myrtle Palmer	W Dale McMurtrey	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63027 Helen Olson

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 19 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 1 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept 15, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3354
Local Reg. No. 484
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 011 Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 2114 Madison Avenue

3. NAME OF DECEASED (Type or Print) a. (First) Hugh b. (Middle) C. c. (Last) Dorrien

4. DATE OF DEATH (Month) (Day) (Year) August 30, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Sept 29, 1893

9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Colonel, retired 05

10b. KIND OF BUSINESS OR INDUSTRY US Army, Infantry

11. BIRTHPLACE (State or foreign country) Soda Springs, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hugh T. Dorrien BIRTHPLACE Salt Lake City, Utah

14. MOTHER'S MAIDEN NAME Lizzie Horsley BIRTHPLACE Soda Springs, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1917 to 1946 4

16. SOCIAL SECURITY NO. 518-54-0199

17. INFORMANT'S OWN SIGNATURE Elsye E. Dorrien ADDRESS 2114 Madison Ave., Boise, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

20 1X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Probable pulmonary & liver infiltration

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-12, 1967, *to* 8-29, 1967, *that I last saw the deceased alive on* 8-29, 1967, *and that death occurred at* 12:50A m., *from the causes and on the date stated above.*

23a. SIGNATURE C. E. Clohessy, M.D. 095 (Degree or title)

23b. ADDRESS Boise, Idaho

23c. DATE SIGNED 8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-2-67

24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 9-5-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER F. Richard Reed

LICENSE NO. E-440

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
SEP 14 1967
Bureau of Vital Statistics

State of Idaho } ss.
County of Ada

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Dorrien Hugh C. (Name on Original Certificate) who died (Was Born or Died) on August 30, 1967 (Date of Event)
in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by family records (Bible Record, Insurance Policy, Etc.) prepared on September 29, 1893 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Full Name of Deceased	Dorrien Hugh C.	Hugh C. Dorrien

Subscribed and sworn to before me this 14th day of September, 1967

Notary Public, residing at Boise Idaho

My commission expires Sept 10, 1970

(Seal)

Signed J. Richard Reed
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

1205 W. Bannock St., Boise, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 14th day of September, 1967

Notary Public, residing at Boise Idaho

My commission expires Sept 10, 1970

(Seal)

Signed Fred E. Walker
(Signature of Any Credible Person)

1205 W. Bannock St., Boise, Idaho
(Street Address, City, State)

FORM DH 60-155

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 484
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2114 Madison Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): DORRIEN
b. (Middle): HUGH
c. (Last): C.

4. DATE OF DEATH (Month) (Day) (Year): August 30, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: Sept. 29, 1893
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Colonel, retired
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army Infantry
11. BIRTHPLACE (State or foreign country): Soda Springs, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Hugh T. Dorrien — BIRTHPLACE: Salt Lake City, Utah
14. MOTHER'S MAIDEN NAME: Lizzie Horsley — BIRTHPLACE: Soda Springs, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): 1917 to 1946
16. SOCIAL SECURITY NO.: 518-54-0199
17. INFORMANT'S OWN SIGNATURE: Elsye E. Dorrien — ADDRESS: 2114 Madison Ave. Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hodgkins Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Probable pulmonary & liver infiltrations

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/12, 1967, *to* 8/29, 1967, *that I last saw the deceased alive on* 8/29, 1967, *and that death occurred at* 12:50a *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): M.D.
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 8/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-2-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-5-67
REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson
25. EMBALMER: F. Richard Reed
LICENSE NO.: E-440

Federal Security Agency
United States Public Health Service
Form DH-63022
FIRM NAME: SUMMERS FUNERAL HOME

SEP 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 10 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 12 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 17 1984

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3355
Local Reg. No. 477
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 31 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3211 State Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 6922 Hummel Drive

3. NAME OF DECEASED (Type or Print)
a. (First) DUANE
b. (Middle) R.
c. (Last) ALTERS

4. DATE OF DEATH (Month) August (Day) 30, (Year) 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH March 24, 1913
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) statistician 08
10b. KIND OF BUSINESS OR INDUSTRY law enforcement
11. BIRTHPLACE (State or foreign country) Sumner, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ray N. Alters — BIRTHPLACE Huntsville, Ill.
14. MOTHER'S MAIDEN NAME Ethel Lockhart — BIRTHPLACE Miller, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 518-07-3677
17. INFORMANT'S OWN SIGNATURE Fern O. Alters — ADDRESS 6922 Hummel Dr. Boise, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) reported cardiac condition
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 9:40a *m., from the causes and on the date stated above.*

23a. SIGNATURE C. D. Paris, Coroner 583 (Degree or title) 4
23b. ADDRESS 3720 Meadow Dr Boise
23c. DATE SIGNED 8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Sept. 1 '67
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery
24d. LOCATION (City, town, or county) Boise, (State) Idaho

DATE REC'D BY LOCAL REG. 8-31-67
REGISTRAR'S SIGNATURE Myrtle Palmer by Dean Olson
25. EMBALMER Fred E. Walker
LICENSE NO. E-483

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Coroner

Certificate of Death

STATE OF IDAHO

State File No. 3356
Local Reg. No. 133
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 010 Ada — SEP 7 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Garden City — c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 010 — b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Garden City
d. STREET ADDRESS (If rural, give location) 201 West 42nd

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHRISTINE	ANN	SALKIELD	August 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	Nov. 19, 1955	12				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME — BIRTHPLACE: Laron Benjamin Salkield — Salt Lake City, Utah
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Mildred Marie Trimble — Blackwell, Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE ADDRESS: X Laron Benjamin Salkield

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by drowning. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Apparent Cramp seizure.
DUE TO (c) From the condition of body when found at bottom of River — I Hr;

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	18	13	000	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 630 PM., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
583 (Degree or title) Coroner	3720 Meadow Drive, Boise.	9-7-67.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/1/1967	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-7-67	Mystle Palmer	Conway Grant	E478

Helen Olson

FIRM NAME: RELYEA MORTUARY, Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 7 - 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3357
Local Reg. No. 19
Reg. Dist. No. 310

Certificate of Death

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 020 Adams 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Meadows
c. STATE (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270 b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural)
d. STREET ADDRESS (If rural, give location) Rt. # 3

3. NAME OF DECEASED (Type or Print)
a. (First) VIRGIL b. (Middle) JOHN c. (Last) LICKLEY

4. DATE OF DEATH (Month) (Day) (Year) Aug. 1, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan. 1, 1898
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cattle Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Marion, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Albert Lickley BIRTHPLACE Michigan
14. MOTHER'S MAIDEN NAME Sarah Barber BIRTHPLACE Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 42 6872
17. INFORMANT'S OWN SIGNATURE X Albert Lickley ADDRESS Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Aparent Massive Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION D.O.A. McCall Hospital
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) McCall (COUNTY) Valley (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 1:45 pm Aug 1 '67 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Heart Attack while visiting daughter

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Burton E Walker 583 (Degree or title) coroner 4
23b. ADDRESS McCall Idaho
23c. DATE SIGNED Aug 5 '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) Jerome, Idaho (State)

DATE REC'D BY LOCAL REG. Aug 14-1967
REGISTRAR'S SIGNATURE Myrtle M Gardner
25. EMBALMER Wilbur L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3358
Local Reg. No. 300
Reg. Dist. No. 15

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural New Meadows
c. LENGTH OF STAY (in this place): 25 yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 020
b. COUNTY: Adams 005
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Meadows
d. STREET ADDRESS (If rural, give location):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4½ miles E. of New Meadows

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAMES	H.	HALBESLEBEN	August 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	never married	Sept. 16, 1938	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sawyer 21	J. I. Morgan Co.	Tico, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jesse Halbesleben	Wisconsin	Ethel Greth	Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-42-3109	August Halbesleben	New Meadows

MEDICAL CERTIFICATION

8214

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken neck, and ~~massive crushing~~ injury to the left shoulder — INTERVAL BETWEEN ONSET AND DEATH: instantaneous

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	4½ mi.E. of New Meadows	13	Adams 020	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Aug. 12, 1967 2 A.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Motorcylce accident

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert E Ham	583 Coroner 4	Box 525 Council, Idaho	8/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 14, 1967	Meadows Valley Cemetery	Meadows, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-18-67		Burton E Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 12 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3359
Local Reg. No. 14
Reg. Dist. No. 300

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams 020 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Council Memorial Hospital 017

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 430
b. COUNTY: Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOE JACK		POWELL	August 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	never married	Dec. 8, 1891	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Packer, Freighter, Guide 04		Meadows, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Powell	Nebraska	Ida McCumpsey	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-28-5489-A	personal records	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-9- , 19 67 , to 8-12 , 19 67 , *that I last saw the deceased alive on* 8-11- / , 19 67 , *and that death occurred at* 3:10a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
154 /	Council, Idaho	8-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 17, 1967	Meadows Valley Cemetery	Meadows Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-17-67		Burton C. Walker	E-386

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: WALKER FUNERAL HOME

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
SEP 19 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3360
Local Reg. No. 17
Reg. Dist. No. 300

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Adams 020 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Council
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Council Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 020 b. COUNTY Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meadows
d. STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
KATIE	ONETA LEVENGOOD	CLAY	8	30	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	married 3	2/27/1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own home	Anaconda, Montana	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
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15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-32-7001	✓ Dick K Clay, son	Meadows, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 157X Carcinoma of Pancreas — INTERVAL BETWEEN ONSET AND DEATH 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-11- , 19 67 , *to* 8-30 , 19 67 , *that I last saw the deceased alive on* 8-30 , 19 67 , *and that death occurred at* 5:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
154	Council, Idaho	8/30/1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/2/1967	Meadows Cemetery	Meadows Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-16-67		Marshall S. Dickerson Jr.	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

~~Regardless of the fact that the person~~ may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3361
Local Reg. No. 218
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY (03) Bannock 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hosp. 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 03 b. COUNTY Bannock
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Pocatello
d. STREET ADDRESS (If rural, give location) 1852 E. Center

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LILLIAN	LEE	KEFAUVER	Aug 1 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	July 25, 1886	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Graham, Virginia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John B. Saunders	Virginia	Lena B. Frazier	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		X Clark L. Price Jr.	Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic extra-renal azotemia
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (B) Papillary adenocarcinoma of the stomach with regional metastases.
DUE TO (c) (2) Achrestic anemia secondary to subtotal gastrectomy. (3) Cerebral arterio-sclerosis, advanced.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
Months. YEARS YEARS YEARS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug. 1, 1967, *to* Aug. 1, 1967, ~~*that I last saw the deceased alive on* Aug 1, 1967~~, *and that death occurred at* 7:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
ARCH WIGLE, M.D 366	1605 North Arthur / Pocatello, Idaho 83201	Aug. 4, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8-4-67	Aultorest Crematory	Ogden Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 7 1967	Maureen Schebler Deputy	John P. Gorman	E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3362
Local Reg. No. 219
Reg. Dist. No. 510

Certificate of Death

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 031 Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1123 La Brea

3. NAME OF DECEASED (Type or Print)
a. (First) RELL
b. (Middle)
c. (Last) MUNGER

4. DATE OF DEATH (Month) (Day) (Year) August 3, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov. 4, 1915
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Foreman
10b. KIND OF BUSINESS OR INDUSTRY: 26 F.M.C.
11. BIRTHPLACE (State or foreign country): Filer, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Burton Munger — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Vilate Sanders — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) XXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mary Munger — ADDRESS: Pocatello, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from —, 19—, to —, 19—, that I ~~last~~ saw the deceased alive on 8-3-, 1967, and that death occurred at 3 m., from the causes and on the date stated above.*

23a. SIGNATURE: Burton J. Johns — 583 (Degree or title) Coroner 4
23b. ADDRESS: Bannock Co Idaho
23c. DATE SIGNED: 8-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: AUG 15 1967
REGISTRAR'S SIGNATURE: Maureen Achelske, Deputy
25. EMBALMER: F. B. Ashby — LICENSE NO. E418

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 6 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3363
Local Reg. No. 224
Reg. Dist. No. 511

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 061
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 223 South Fisher St.

3. NAME OF DECEASED (Type or Print)
a. (First) VINCENT
b. (Middle) MUGUIRA
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) August 5, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH April 19, 1889
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Navarniz, Spain
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Jose A. Muguira — BIRTHPLACE Spain
14. MOTHER'S MAIDEN NAME Josephine — BIRTHPLACE Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-42-8084 A
17. INFORMANT'S OWN SIGNATURE Paula Muguira — ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure Ind.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Pulmonary emphysema
DUE TO (c) Arteriosclerotic heart dis.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 8/1/67
19b. MAJOR FINDINGS OF OPERATION Incarc. epigastric hernia
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 1, 1967, *to* August 5, 1967, *that I last saw the deceased alive on* August 5, 1967, *and that death occurred at* 1055p.m., *from the causes and on the date stated above.*

23a. SIGNATURE R. R. Gorton 185 (Degree or title) M.D.
23b. ADDRESS Pocatello, Idaho
23c. DATE SIGNED August 8, 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE August 9, 1967
24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery
24d. LOCATION (City, town, or county) Blackfoot, (State) Idaho

DATE REC'D BY LOCAL REG. AUG 21 1967
REGISTRAR'S SIGNATURE Sally Kellogg
25. EMBALMER C. Dean Hill — LICENSE NO. E-466

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 2000

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3364
Local Reg. No. 330
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock 001
b. CITY OR TOWN Pocatello
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Nursing Home 299

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) Bannock Nursing Home

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) A. c. (Last) Ward

4. DATE OF DEATH (Month) (Day) (Year): Aug. 5, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 18, 1878

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Contractor

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Hyrum, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George P. Ward
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Mary Bindrup
BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-12-7662

17. INFORMANT'S OWN SIGNATURE: Martha Ward
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardiovascular Disease with acute myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July-67 19__, *to* 8-5-67, 19__, *that I last saw the deceased alive on* 8-5-67, 19__, *and that death occurred at* 8:20 m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] MD 362 (Degree or title)

23b. ADDRESS Pocatello Idaho

23c. DATE SIGNED 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 9, 1967

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill

24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: AUG 14 1967

REGISTRAR'S SIGNATURE: Maureen Schelske, Deputy

25. EMBALMER: [signature]

LICENSE NO.: E418

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3365
Local Reg. No. 221
Reg. Dist. No. 510

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 018 Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 031
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) Bannock Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First) Carl
b. (Middle) Levin
c. (Last) Hayden

4. DATE OF DEATH (Month) Aug. (Day) 7 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH June 11, 1887
9. AGE (In years last birthday) 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Bengt Anderson — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Johanna Sofia Johnson — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs. Ben L. Hayden — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 3 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senibety — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Pocatello (COUNTY) Bannock (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 4, 1967, *to* Aug 7, 1967, *that I last saw the deceased alive on* Aug 6, 1967, *and that death occurred at* 2:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE C. E. Groom, M.D. 190 (Degree or title)
23b. ADDRESS 1505 E. Center
23c. DATE SIGNED 8/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE August 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Mountian View
24d. LOCATION (City, town, or county) Pocatello (State) Idaho

DATE REC'D BY LOCAL REG. AUG 14 1967
REGISTRAR'S SIGNATURE Maureen Schelska, Deputy
25. EMBALMER J. B. Ashby
LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

BIRTH NO. 67-7317

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3366
Local Reg. No. 223
Reg. Dist. No. 57

1. PLACE OF DEATH
a. COUNTY 031 Bannock — AUG 16 1967 — 301
b. CITY OR TOWN Pocatello — c. LENGTH OF STAY IN (this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION Bannock Mem. Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 030 — b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Rt. 3, South
d. STREET ADDRESS (If rural, give location) South Main Extension

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	CHARLES	RANTS	Aug. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	Aug. 8, 1967	0	0	1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 021	None	Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lauren Rants	Washington	Catherine Groccia	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	Lauren Rants	Pocatello, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION — 7735

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory distress syndrome — INTERVAL BETWEEN ONSET AND DEATH 24hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) premature
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/6, 1967, *to* 8/9, 1967, *that I last saw the deceased alive on* 8/9, 1967, *and that death occurred at* 11:10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Raymond Boehme MD	527 S. 12 Pocatello	8/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-11-67	Mountainview Cem.	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
AUG 15 1967	Maureen Ackeleke, Deputy	John P. Hamm	E-292

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Downard Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3367
Local Reg. No. 225
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1210 East Halliday Street

3. NAME OF DECEASED (Type or Print)
a. (First): CLIFFORD
b. (Middle):
c. (Last): KIRKENDALL

4. DATE OF DEATH (Month) (Day) (Year): August 12 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: November 9, 1893
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Partner (Retired) 26
10b. KIND OF BUSINESS OR INDUSTRY: Sports Shop
11. BIRTHPLACE (State or foreign country): Lander Wyoming
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Fletcher Kirkendall — BIRTHPLACE: St. Joseph, Mo.
14. MOTHER'S MAIDEN NAME: Elizabeth Stahl — BIRTHPLACE: Fort Bridger, Wyo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 519-40-4166
17. INFORMANT'S OWN SIGNATURE: Clifford Kirkendall Jr. — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Carcinoma of Prostate & Colon
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: Sept. 63 Oct. 66
19b. MAJOR FINDINGS OF OPERATION: Sept 63 - Ca of Prostate - Oct. '66 Ca of Colon
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello Bannock Ida
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1960, 19 67, *to* Aug. 12, 19 67, *that I last saw the deceased alive on* Aug. 12, 19 67, *and that death occurred at* 8:20p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C E Groom, M.D. 190
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Aug. 15, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: AUG 23 1967
REGISTRAR'S SIGNATURE: Sally Kellogg
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 27 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 1 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3368
Local Reg. No. 223
Reg. Dist. No. 51

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA, Bannock Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY 555 San Mateo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) San Mateo
d. STREET ADDRESS (If rural, give location) 888 Foster City Blvd. Apt. H-1

3. NAME OF DECEASED (Type or Print)
a. (First) GARY
b. (Middle) MICHAEL 000
c. (Last) FREDSON

4. DATE OF DEATH (Month) (Day) (Year) Aug. 12, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 2
8. DATE OF BIRTH Aug. 25, 1943
9. AGE (In years last birthday) 23
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY Wholesale
11. BIRTHPLACE (State or foreign country) California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Kenneth Fredson
BIRTHPLACE California
14. MOTHER'S MAIDEN NAME Mary Basom
BIRTHPLACE California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 553-56-6204
17. INFORMANT'S OWN SIGNATURE Deceased Personal Records
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8254 Skull Fracture, basal
Fractures of Facial Bones.
INTERVAL BETWEEN ONSET AND DEATH Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture, Cervical Vert. Comp. Fract. L. Leg (3)

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) City Street 04
21c. (CITY, TOWN, OR TOWNSHIP) 03 Pocatello (COUNTY) Bannock (STATE) Ida.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-12-67 1:4 m
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Car out of Control.

22. I hereby certify that I attended the deceased from — , 19 — , to — , 19 — , that I last saw the deceased alive on 8-12 , 1967 , and that death occurred at 1:4 m., from the causes and on the date stated above.

23a. SIGNATURE Burton W. Colin 583 (Degree or title) Coroner
23b. ADDRESS Bannock Co Idaho
23c. DATE SIGNED 8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 8-13-67
24c. NAME OF CEMETERY OR CREMATORY Holy Sepulchre Cem.
24d. LOCATION (City, town, or county) (State) Oakland, California

DATE REC'D BY LOCAL REG. AUG 15 1967
REGISTRAR'S SIGNATURE Maureen Scholsky Deputy
25. EMBALMER John P. Howard
LICENSE NO. E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Doward Funeral Home

AUG 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to supply the facts shall sign HIS name in addition to giving the source of information.

AUG 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 20 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3369
Local Reg. No. 226
Reg. Dist. No. 511

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho 040
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. STREET ADDRESS (If rural, give location) 395 North 7th

3. NAME OF DECEASED (Type or Print)
a. (First) Charles
b. (Middle) Edward
c. (Last) Grunig

4. DATE OF DEATH (Month) (Day) (Year) Aug. 13. 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 8. 1893
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Switch
10b. KIND OF BUSINESS OR INDUSTRY Engineer U.P.R.R.
11. BIRTHPLACE (State or foreign country) Montpelier, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Carl E. Grunig — BIRTHPLACE Switzerland
14. MOTHER'S MAIDEN NAME Christine Kunzler — BIRTHPLACE Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 712-05-3208
17. INFORMANT'S OWN SIGNATURE Mrs. C. E. Grunig — ADDRESS Montpelier Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

491X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ASHD c failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchopneumonia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emb. Senia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/13, 1967, *to* 8/13, 1967, *that I last saw the deceased alive on* 8/13, 1967, *and that death occurred at* 10:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE R. Horton MD 185 (Degree or title)
23b. ADDRESS Pocatello Ida
23c. DATE SIGNED 8/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Aug 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery
24d. LOCATION (City, town, or county) (State) Montpelier Idaho

DATE REC'D BY LOCAL REG. AUG 23 1967
REGISTRAR'S SIGNATURE Sally Kellogg
25. EMBALMER John P. Grover
LICENSE NO. E-292

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Matthews Mortuary

AUG 30 1967

MAR 02 2016

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

[redacted]

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3370
Local Reg. No. 0228
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
AUG 28 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN: Pocatello
c. LENGTH OF TIME AT THIS PLACE: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA St. Anthony Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 900 Highland Blvd.

3. NAME OF DECEASED (Type or Print): a. (First) A, b. (Middle) SPENCER c. (Last) FORD

4. DATE OF DEATH: (Month) (Day) (Year) Aug. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married 2	May 23, 1906	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
President 26	Ford Music Co.	Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur W. Ford	Utah	Henrietta Madsen	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-26-3661	Florence Ford	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9140

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Electrical shock — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident 1	home 01	Pocatello 13	Bannock 031	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
8 15 1967 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Home accident

22. *I hereby certify that I attended the deceased from* 8-15, 1967, *to* _____, 19___, *that I last saw the deceased alive on* DOA, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas J. McElvitt 341	MD1	804 E. Center	8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-18-67	Mountainview Cem.	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-22-67	Sally Kellogg	John P. Gannon	E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3371
Local Reg. No. 227
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Bannock Mem.Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) Route #3 Box 178

3. NAME OF DECEASED (Type or Print)
a. (First) DEBRA
b. (Middle) ANN 000
c. (Last) COFFIN

4. DATE OF DEATH (Month) (Day) (Year) August 15, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: Jan. 5, 1960
9. AGE (In years last birthday): 7 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Public school
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Blaine Coffin — BIRTHPLACE: Downey, Idaho
14. MOTHER'S MAIDEN NAME: Ann Marie Gregerson — BIRTHPLACE: Pocatello, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) XXXX
16. SOCIAL SECURITY NO. XXX
17. INFORMANT'S OWN SIGNATURE: Blaine Coffin — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 9140 Electrocution, Toaster — INTERVAL BETWEEN ONSET AND DEATH: 5

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) (Probable) Autopsy not performed because insufficient permission was obtained. Limited autopsy not sufficient for absolute proof.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 031 (STATE) Bannock Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-15-67 9:30 A.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fell on defective Toaster.

22. *I hereby certify that I attended the deceased from* — *, 19*__, *to* — *, 19*__, *that I* ~~last~~ *saw the deceased* ~~alive on~~ dead 8-15-, 1967, *and that death occurred at* 9:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: Burton John 583 (Degree or title) Coroner 4
23b. ADDRESS: Bannock Co. Idaho
23c. DATE SIGNED: 8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug.17,1967
24c. NAME OF CEMETERY OR CREMATORY: Downey Cemetery
24d. LOCATION (City, town, or county) (State): Downey, Bannock, Idaho

DATE REC'D BY LOCAL REG.: 8-18-67
REGISTRAR'S SIGNATURE: Sally Kellogg
25. EMBALMER: T.B. Ashley — LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

REC[illegible] Certificate of Death

STATE OF IDAHO

State File No. 3372
Local Reg. No. 229
Reg. Dist. No. 510

BIRTH NO.

SEP 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 03 / Bannock
b. CITY OR TOWN Pocatelle
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 03 / b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatelle
d. STREET ADDRESS (If rural, give location) 729 West Center Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	DAVID	NAYLOR	LESLEY	August	18	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	February 3, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Manager 26	Apartment House	Berdon, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Lesley	Nebraska	Mary King	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War I 3	546-07-0937	Ollie Lesley	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	INTERVAL BETWEEN ONSET AND DEATH
	Acute Cerebral Hemorrhage	4 hours
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) Arteriosclerotic Hypertension	1 year
	DUE TO (c)	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Pocatello Bannock Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ~~Aug 17~~ 1967, *to* August 18 1967, *that I last saw the deceased alive on* August 18, 1967, *and that death occurred at* 12 noon *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R P Howland MD	Pocatello, Idaho	Aug. 21, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 21, 1967	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-29-67	Gloria Dopita	Jack Henderson	E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 21 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3373
Local Reg. No. 235
Reg. Dist. No. 5-1

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 03 Bannock — SEP 8 1967 — 000
b. CITY OR TOWN Pocatello — c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390 — b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural (American Falls)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	BEN	GEORGE	KOPP	Aug.	19,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 20, 1894	72	10	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Gearranburg, Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-24-0241	Rudolf H. Kopp	Am. Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Crush Injury Right Leg
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Old Prostatic Carcinoma-med Rx.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Volkmon Vascular Ischemia	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Farm 02	American Falls	13 Power 39	Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
8-12-67 m.		Tractor Wheel Rolled over Rt. Leg

22. *I hereby certify that I attended the deceased from* 8-12-67, 19____, *to* 8-19-67, 19____, *that I last saw the deceased alive on* 8-19-67 19____, *and that death occurred at* 3:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
016 J M Bacon MD	M. D.	1352 East Center, Poc. Idaho	8-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	8-23-67	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-29-67	Gloria Dopita	Bud Kelly Bud Kelly	E-467

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3374
Local Reg. No. 231
Reg. Dist. No. 510

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 23 Bannock — SEP 5 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello — LENGTH OF STAY (If dead on arrival, write DOA in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 03 — b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 745 North 7th Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARION	AGNES	BETTY	August 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Aug. 14, 1924	43				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Pocatello, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George St. Marie	Pocatello, Ida.	Harriet Bean	Pocatello, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXXXX			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8164

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture, Skull, Basal — INTERVAL BETWEEN ONSET AND DEATH Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Compound Fractures L. Leg.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident. 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Interstate 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 130 (STATE) Bannock Idaho.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-19-67-12:10 P.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car + Motorcycle Collision

22. *I hereby certify that I attended the deceased from* — 19—, *to* — 19—, *that I last saw the deceased alive on* 8-19-, 1967, *and that death occurred at* 12:10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton Hyde	583 Coroner	Bannock Co. Ida	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 22, 1967	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/28/67	Gloria Dopita	John P. Lomm	E292

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

SEP 22 1967

JUN 21 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3375
Local Reg. No. 236
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 031 b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 745 North 7th Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HOMER	MILES	BETTY	Aug. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 27, 1927	39				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
10	P.F.E.	Pocatello, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Thomas Betty		Vera	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Mrs. Vera Betty	Pocatello, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8154

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture, Skull, Basal — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 030 (STATE)
Accident	Interstate 86	Bannock, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
8-19-67-12:10 p.m.	2	Car + Motorcycle collision

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* 8-19-, 1967, *and that death occurred at* 12:10 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton Hyde	583 Coroner 4	Bannock Co Ida	8-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 22, 1967	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-67	Gloria Dopita	[signature]	F416

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Manning Funeral Chapel

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 21 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3376
Local Reg. No. 236
Reg. Dist. No. 511

RECEIVED SEP 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 1515 Kimberly Road

3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) c. (Last) Laib
4. DATE OF DEATH (Month) (Day) (Year) August 20, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH March 17, 1915
9. AGE (In years last birthday) 52 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) heavy equipment operator
10b. KIND OF BUSINESS OR INDUSTRY Road Construction
11. BIRTHPLACE (State or foreign country) Arena, North Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Laib BIRTHPLACE Odessa, Russia
14. MOTHER'S MAIDEN NAME Bertha Rassmann BIRTHPLACE Odessa, Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-14-0362
17. INFORMANT'S OWN SIGNATURE ADDRESS X Gary D. Laib Twin Falls, Idaho

MEDICAL CERTIFICATION

0637

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized peritonitis — INTERVAL BETWEEN ONSET AND DEATH: 3-1/2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gangrene of entire colon and multiple small bowel fistulas — 3-1/2 wks.
DUE TO (c) Clostridium perfringens. — 3-1/2 wks.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bilateral bronchopneumonia — 3 days

19a. DATE OF OPERATION 7-24-67
19b. MAJOR FINDINGS OF OPERATION As above.
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24-67, 19__, *to* 8-20, 1967, *that I last saw the deceased alive on* 8-20, 1967, *and that death occurred at* 8:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Melvin M. Graves, M.D. (Degree or title)
23b. ADDRESS 1448 East Center Pocatello, Idaho
23c. DATE SIGNED 8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Aug. 24, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 8-31-67
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER John P. Grossman
LICENSE NO. E292
FIRM NAME: WHITE MORTUARY, Twin Falls, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3377
Local Reg. No. 233
Reg. Dist. No. 510

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 03 Bannock
b. CITY OR TOWN Pocatello
(If outside corporate limits, write RURAL and give township) | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION DOA Bannock Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 03
b. COUNTY Bannock
c. CITY OR TOWN Pocatello
(If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location) 171 Rosewood

3. NAME OF DECEASED (Type or Print)
a. (First) ELIZA
b. (Middle) EDWINA
c. (Last) BASSIL

4. DATE OF DEATH (Month) (Day) (Year) August 24, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Nov. 5, 1876

9. AGE (In years last birthday) 91
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) West Portage, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John A. Thornton
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Catherine E. Miller
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) xxxx

16. SOCIAL SECURITY NO. 519 60 2951

17. INFORMANT'S OWN SIGNATURE Lena Hackman
ADDRESS

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — , 19 — *to* — , 19 — , *that I last saw the deceased alive on* 8-24, 1967, *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE Burton D. Ray
583 (Degree or title) Coroner 4

23b. ADDRESS Bannock Co. Idaho

23c. DATE SIGNED 8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.

24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. 8/31/67

REGISTRAR'S SIGNATURE Gloria Doane

25. EMBALMER T. B. Manning

LICENSE NO. E48

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3378
Local Reg. No. 234
Reg. Dist. No. 511

Certificate of Death

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 030 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCammon
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Near train station 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 030
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCammon
d. STREET ADDRESS (If rural, give location) McCammon, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) Jacqueline
b. (Middle)
c. (Last) Kinney

4. DATE OF DEATH (Month) August (Day) 24, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH Jan. 30, 1963
9. AGE (In years last birthday) 4 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) XXXXXX 02
10b. KIND OF BUSINESS OR INDUSTRY XXXXXX
11. BIRTHPLACE (State or foreign country) Downey, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Maurice E. Kinney. BIRTHPLACE Pocatello, Ida.
14. MOTHER'S MAIDEN NAME Betty Neeser BIRTHPLACE McCammon, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XXXX (If yes, give war or dates of service) XXXXX
16. SOCIAL SECURITY NO. XXXXX
17. INFORMANT'S OWN SIGNATURE Maurice E Kinney ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8021

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive, crushing + penetrating wound vault of cranium with loss of brain substance

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Immed.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) R.R. Station 10
21c. (CITY, TOWN, OR TOWNSHIP) McCammon 13 **(COUNTY)** Bannock 030 **(STATE)** Idaho

21d. TIME OF INJURY (Month) 8-24-67 (Day) (Year) (Hour) 8 p.m. 50
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Struck by train.

22. *I hereby certify that I attended the deceased from* 2, 19__, *to* 2, 19__, *that I ~~last~~ saw the deceased* dead *on* 8-24-67, 19__, *and that death occurred at* 8:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton H John 583 (Degree or title) Coroner 4
23b. ADDRESS Bannock Co. Ida.
23c. DATE SIGNED 8-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE Aug. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY McCammon
24d. LOCATION (City, town, or county) McCammon, Bannock, Idaho (State)

DATE REC'D BY LOCAL REG. 8-28-67
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER [signature]
LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3379
Local Reg. No. 232
Reg. Dist. No. 511

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 030 Bannock 135
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey
DURATION OF STAY (in this place) life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Marsh Valley Hospital 08

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 030 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Downey, Idaho
d. STREET ADDRESS (If rural, give location) -- spouse: Marlyn Treasure

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	WARREN	DE VERE	BARNES		AUG	24	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Sept 29, 1931	35				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming, bus driver 44 -		Downey, Bannock, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
WARREN OGDEN BARNES	Downey, Idaho	LETTIE HENDERSON	Swan Lake, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	RFD ADDRESS
yes	Korean War 1951	Not available	Warren O. Barnes	Downey, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chest and internal injuries — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) accident
DUE TO (c) Combine tipped on patient

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
1	farm - Deep Hill 02	Downey,	Bannock	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
8	24	67	10:30 a.m.		Combine rolled on patient

22. *I hereby certify that I attended the deceased from* _____, 19__ to Aug 24, 1967, *that I last saw the deceased alive on* Aug, 19__, *and that death occurred at* 11 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Downey	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
burial	Aug 28, 1967	Downey City Cemetery	Downey, Bannock	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 28 67	Orissa Salvesen	Raiford G. Benson	E-351

FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. SEP 28 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 8 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3380
Local Reg. No. 237
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 03 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Mercy Hosp. 09

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello--RURAL
d. STREET ADDRESS (If rural, give location) Rte. 1, Box 107

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) c. (Last) CAMPANELLA

4. DATE OF DEATH (Month) Aug. (Day) 26 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Jan. 6, 1887

9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 09

10b. KIND OF BUSINESS OR INDUSTRY Livestock

11. BIRTHPLACE (State or foreign country) Boiano, Campobass, Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Campanella — BIRTHPLACE Italy

14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-40-4732

17. INFORMANT'S OWN SIGNATURE Mrs Thomas Campanella — ADDRESS Pocatello

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart dis. 1yr.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. CITY, TOWN, OR TOWNSHIP Pocatello (COUNTY) (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 23 19 67 *to* Aug 26 19 67, *that I last saw the deceased alive on* Aug 25 19 67, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE R. D. Howard MD 248 (Degree or title) — **23b. ADDRESS** Pocatello — **23c. DATE SIGNED** 8-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 29 Aug '67

24c. NAME OF CEMETERY OR CREMATORY Mountainview

24d. LOCATION (City, town, or county) Pocatello (State) Idaho

DATE REC'D BY LOCAL REG. 9-1-67

REGISTRAR'S SIGNATURE Gloria Doyle

25. EMBALMER Dwight W Knapp — LICENSE NO. 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 9 1968

MAR 7 1972

MAY 8 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3381
Local Reg. No. 238
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 031 b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 201 Wilson

3. NAME OF DECEASED (Type or Print)
a. (First) SAMUEL b. (Middle) LELAND c. (Last) FRECKLETON

4. DATE OF DEATH (Month) (Day) (Year) August 27, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH June 27, 1893
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Sterling, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel L. Freckleton — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Mary S. Edwards — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) XXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Ned P. Freckleton — ADDRESS Pocatello, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 2 years.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adenocarcinoma of the prostate.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

177X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 26, 1967 *to* Aug 27, 1967, *that I last saw the deceased alive on* Aug 27, 1967, *and that death occurred at* 3:10 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Jay P. Merkley (Degree or title) Jay P. Merkley, M.D. 334
23b. ADDRESS P.O. Box 4064 Pocatello, Idaho
23c. DATE SIGNED 8/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. 9-1-67
REGISTRAR'S SIGNATURE Glorea Dopita
25. EMBALMER F. B. Ashby — LICENSE NO. E 418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3382
Local Reg. No. 244
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 03 / Bannock 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 03
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 158 Davis Drive

3. NAME OF DECEASED (Type or Print)
a. (First) MARY
b. (Middle) LOU
c. (Last) ELLIOTT

4. DATE OF DEATH (Month) (Day) (Year) Aug. 31, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 3, 1918
9. AGE (In years last birthday) 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School teacher 12
10b. KIND OF BUSINESS OR INDUSTRY Education
11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Eugene S. Hart — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Nellie Osmond — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) XXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Howard D. Elliott — ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

170X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Carcinoma breast
DUE TO (c) Sen metastasis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE R. Corton 185 (Degree or title) MD
23b. ADDRESS Pocatello
23c. DATE SIGNED 9/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY Restlawn Mem. Gardens
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. SEP 11 1967
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER F. B. Ashton
LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 9 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3383
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 840 Bear Lake AUG 21 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
c. LENGTH OF STAY (If outside corporate limits, write RURAL and give township) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 040 b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. STREET ADDRESS (If rural, give location) 756 Grant

3. NAME OF DECEASED (Type or Print)
a. (First) James b. (Middle) B. c. (Last) Bruce

4. DATE OF DEATH (Month) (Day) (Year) Aug. 6. 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 21, 1891
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Forest
10b. KIND OF BUSINESS OR INDUSTRY Ranger 08
11. BIRTHPLACE (State or foreign country) Smoot Wyoming
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George W. Bruce — BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME Helen W. Niel — BIRTHPLACE Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-40-1038
17. INFORMANT'S OWN SIGNATURE Helen Ipsen — ADDRESS Montpelier Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis and
DUE TO (c) hypertension — 7 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 8-6-67
19b. MAJOR FINDINGS OF OPERATION Physical Examination
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1960, *to* 8-6, 1967, *that I last saw the deceased alive on* 8-6-67, 19__ *and that death occurred at* 5:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Reed Rich 439 (Degree or title) Md
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery
24d. LOCATION (City, town, or county) (State) Montpelier Idaho

DATE REC'D BY LOCAL REG. 8-9-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcimb
25. EMBALMER Nils Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3384
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 040 Bear Lake 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Idaho 040 b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. STREET ADDRESS (If rural, give location) 236 N. 7th St.

3. NAME OF DECEASED (Type or Print)
a. (First) Martin b. (Middle) Lloyd c. (Last) Ipsen

4. DATE OF DEATH (Month) (Day) (Year) Aug. 9 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 4, 1897
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.P.R.R. Car Inspector & Farmer
10b. KIND OF BUSINESS OR INDUSTRY 10
11. BIRTHPLACE (State or foreign country) Mantua, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John P. Ipsen — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Caroline Larsen — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I 3 4201
16. SOCIAL SECURITY NO. 529-26-0690
17. INFORMANT'S OWN SIGNATURE Mrs. Grace Ipsen — ADDRESS Montpelier

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH 15 MIN

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) HYPERTENSIVE HT DISEASE 5 YRS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. EMPHYSEMA.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* JAN *19*62 *to* 9 AUG *19*67, *that I last saw the deceased alive on* 9 AUG, *19*67, *and that death occurred at* 6 pm *m., from the causes and on the date stated above.*

23a. SIGNATURE J W Schoze DVM (Degree or title) 458-1
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 12 1967
24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery
24d. LOCATION (City, town, or county) Montpelier (State) Idaho

DATE REC'D BY LOCAL REG. 8-19-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinsky
25. EMBALMER Nile Matthews — LICENSE NO. E359
FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3385
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

STATE OF IDAHO

BIRTH NO. 67-7385

RECEIVED AUG 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 040 Bear Lake 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 040 b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Charles Idaho.
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Milton b. (Middle) Paul 024 c. (Last) Edghill

4. DATE OF DEATH (Month) (Day) (Year) Aug 12 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Aug 12 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 5 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Montpelier Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Donald Edghill BIRTHPLACE Montpelier Ida
14. MOTHER'S MAIDEN NAME La Von Anderson BIRTHPLACE Bassett Neb.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Donald Edghill ADDRESS St. Charles Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 5 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-12, 1967, *to* 8-12, 1967, *that I last saw the deceased alive on* 8-12, 1967, *and that death occurred at* 10:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Paul B. Damer 126 (Degree or title) MD
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 8-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 14 1967
24c. NAME OF CEMETERY OR CREMATORY Fish Haven Cemetery
24d. LOCATION (City, town, or county) (State) Fish Haven Idaho

DATE REC'D BY LOCAL REG. 8-25-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinsky
25. EMBALMER Nile Matthews
LICENSE NO. E369
FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3386
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 040
a. COUNTY Bear Lake 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
c. LENGTH OF STAY (If in this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Utah 45
b. COUNTY 555 Rich
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Laketown, Utah
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Lois b. (Middle) Arlene Beck c. (Last) Weston

4. DATE OF DEATH (Month) (Day) (Year) Aug. 19, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 2, 1936
9. AGE (In years last birthday) 31 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ovid, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Maurice Beck BIRTHPLACE Lanark, Idaho
14. MOTHER'S MAIDEN NAME Virginia Phelps BIRTHPLACE Montpelier, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-38-2647
17. INFORMANT'S OWN SIGNATURE Joseph S. Weston ADDRESS Laketown Ut.

431X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1959, *to* Aug, 1967, *that I last saw the deceased alive on* 8-19, 1967, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Paul [illegible] 126 (Degree or title) MD
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY Laketown Cemetery
24d. LOCATION (City, town, or county) Laketown (State) Utah

DATE REC'D BY LOCAL REG. 8-25-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinski
25. EMBALMER Nile Matthews LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3387
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 040 Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Ida.
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 040 b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier, Idaho.
d. STREET ADDRESS (If rural, give location) 737 Jackson St.

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) Marie 024 c. (Last) Gambling

4. DATE OF DEATH (Month) (Day) (Year) Aug. 23, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Mar. 7, 1891
9. AGE (In years last birthday) 76 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Tolne Hjorring, Denmark
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nels Carlsen BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Julia M. Larsen BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-30-1152
17. INFORMANT'S OWN SIGNATURE Elna Connelly ADDRESS Pocatello

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

593X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Kidney failure — INTERVAL BETWEEN ONSET AND DEATH 2-3 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) c̄ Uremia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on* 8-23, 1967, *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Paul C. Waines 126 (Degree or title) M.D.
23b. ADDRESS Montpelier, Idaho
23c. DATE SIGNED 8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 26 1967
24c. NAME OF CEMETERY OR CREMATORY Sharon Cemetery
24d. LOCATION (City, town, or county) (State) Sharon Idaho

DATE REC'D BY LOCAL REG. 8-25-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinski
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-65021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3388
Local Reg. No.
Reg. Dist. No. 552

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 040 Bear Lake 306
b. CITY OR TOWN (If outside corporate limits, write RURAL or township) Montpelier Ida.
c. LENGTH OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 040
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. STREET ADDRESS (If rural, give location) 725 Jefferson St.

3. NAME OF DECEASED (Type or Print) a. (First) Irl b. (Middle) C. 024 c. (Last) Nye

4. DATE OF DEATH (Month) (Day) (Year) Aug. 26 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 9, 1896
9. AGE (In years last birthday) 71. If under 1 year: Months, Days. If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawmill Owner & operator
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Paris Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James S Nye
BIRTHPLACE Ogden Utah
14. MOTHER'S MAIDEN NAME Minnie Chapneys
BIRTHPLACE London England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO. 518-38-9360
17. INFORMANT'S OWN SIGNATURE Wendell M Nye
ADDRESS Boise Idaho

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 6 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on 8-26, 1967 and that death occurred at 7 Am m., from the causes and on the date stated above.*

23a. SIGNATURE Paul B Waines 126 (Degree or title) MD
23b. ADDRESS Montpelier Ida
23c. DATE SIGNED 8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 29 1967
24c. NAME OF CEMETERY OR CREMATORY Liberty Idaho
24d. LOCATION (City, town, or county) (State) Liberty Idaho.

DATE REC'D BY LOCAL REG. 9-1-1967
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinsky
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 29 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 20 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

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APR 06 2005

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3389
Local Reg. No. 29
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Benewah 050 — SEP 5 1967 — Bureau of Vital Statistics — 3-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St Maries
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48 — b. COUNTY: Whitman 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tekoa
d. STREET ADDRESS (If rural, give location): **

3. NAME OF DECEASED (Type or Print): a. (First) Hilda — b. (Middle) Marie 025 — c. (Last) Fink

4. DATE OF DEATH: (Month) August (Day) 18 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
F	Caucasian	married 3	5-12-1902	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Cleveland Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Reker	**	Emma Obrock	--

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		--	Beyde Fink (H.E.Kimball)	Tekoa, Wa.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — Unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiac anemia — 6 mos

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-12, 1967, *to* 8-18, 1967, *that I last saw the deceased alive on* 8-18, 1967, *and that death occurred at* 9:17 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. O. [illegible] 533 MD	St. Maries, Idaho	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	8-22-1967	Goldenrod cemetery	Tekoa Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-67	Wanda Dimick	H.E. Kimball	E 269

FIRM NAME: Kimball Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED SEP 11 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3390
Local Reg. No. 30
Reg. Dist. No. 130

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 050 Benewah

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries

c. LENGTH OF STAY IN THIS PLACE: 10 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho b. COUNTY: 050 Benewah

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries

d. STREET ADDRESS (If rural, give location): 402 South 14th

3. NAME OF DECEASED (Type or Print): a. (First) Leslie b. (Middle) Jerald 023 c. (Last) Kerrick

4. DATE OF DEATH (Month) (Day) (Year): August 27 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 12, 1894

9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Manager of

10b. KIND OF BUSINESS OR INDUSTRY: W.W.Power, St. Maries

11. BIRTHPLACE (State or foreign country): Utah

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: J. E. Kerrick — BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Minnie Cockerline — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. One 3

16. SOCIAL SECURITY NO.: 533031063

17. INFORMANT'S OWN SIGNATURE: John C. Kerrick — ADDRESS: Spokane Wash.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Thrombosis	11 days.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Gen. Arteriosderosis	2 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Fracture left fibula	11 days.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 July, 1967, *to* 27 Aug, 1967, *that I last saw the deceased alive on* 27 Aug, 1967, *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. Sullivan M.D.

23b. ADDRESS: St. Maries Idaho

23c. DATE SIGNED: 28 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 30, 1967

24c. NAME OF CEMETERY OR CREMATORY: Woodlawn

24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: 9-7-67

REGISTRAR'S SIGNATURE: Wanda Dimick

25. EMBALMER: Gerald E. Browning

LICENSE NO.: E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3391
Local Reg. No. 99
Reg. Dist. No. 600

BIRTH NO.

RECEIVED AUG 29 1967 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 06
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 288 N. University Ave

3. NAME OF DECEASED (Type or Print)
a. (First): Moroni
b. (Middle): Leonard
c. (Last): Mecham

4. DATE OF DEATH: (Month) 7 (Day) 25 (Year) 67

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 18, 1892

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Ret. 24

10b. KIND OF BUSINESS OR INDUSTRY: Salesman 2

11. BIRTHPLACE (State or foreign country): Riverdale Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Moroni Mecham
BIRTHPLACE: Richfield Utah

14. MOTHER'S MAIDEN NAME: Susan Lyon
BIRTHPLACE: Hyde Park Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-14-2[illegible]

17. INFORMANT'S OWN SIGNATURE: M. Mecham
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic cardio-vascular disease
INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July, 1963, *to* 25 July, 1967, *that I last saw the deceased alive on* 15 July, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Walter G Hoge MD 234 (Degree or title)
23b. ADDRESS: Blackfoot Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify):
24b. DATE: 7-28-67
24c. NAME OF CEMETERY OR CREMATORY: Firth
24d. LOCATION (City, town, or county) (State): Firth Idaho

DATE REC'D BY LOCAL REG.: Aug 23, 1967
REGISTRAR'S SIGNATURE: Jack B Jelke
25. EMBALMER: Gary L. Nelder
LICENSE NO.: E444
FIRM NAME: Nelder Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3392
Local Reg. No. 94
Reg. Dist. No. 600

RECEIVED
AUG 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN Blackfoot
LENGTH OF STAY (in this place) 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham County Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 402 Grant St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	JOHN	SAMUEL	NORMAN	August	4	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed	August 1, 1881	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	agriculture	Layton, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Norman	England	Sarah E. Hodson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-60-4116	Melba Miller	Shelley, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4201 Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH 5mn.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* August 4, 1967, *to* August 4, 1967, *that I last saw the deceased alive on* August 4, 1967, *and that death occurred at* 6:45p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Blackfoot, Idaho	August 7, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	August 8, 1967	Grove City Cemetery	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-9-67	Dorothy J. Jones	Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3393
Local Reg. No. 95
Reg. Dist. No. 600

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 1 moz days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print)
a. (First) INEZ
b. (Middle) J.
c. (Last) INGALLS

4. DATE OF DEATH (Month) (Day) (Year) August 9, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 28, 1891
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Marshall E. Bosom — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Clara Vanostram — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mary Payne ADDRESS Medical Records, State Hospital South

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH 12 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Mural Thrombi of Heart — 2 weeks
DUE TO (c) Bronchopneumonia — 24 hours

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Arteriosclerotic heart disease; marked dibility, senility & obesity; Diabetis Mellitus &

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Ulcer left leg; Hypothyroidism.
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 July, 19 67, *to* 9 August, 19 67, *that I last saw the deceased alive on* 9 August, 1967, *and that death occurred at* 4:30 a m., *from the causes and on the date stated above.*

23a. SIGNATURE A. Stillinger M.D. 594 (Degree or title)
23b. ADDRESS State Hospital South Blackfoot, Idaho
23c. DATE SIGNED 9 August 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 8-9-67
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) Rupert, (State) Idaho

DATE REC'D BY LOCAL REG. Aug 17, 1967
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER Howard Packham
LICENSE NO. E-338

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Howard Packham Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3394
Local Reg. No. 98
Reg. Dist. No. 600

BIRTH NO.

RECEIVED AUG 21 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 06 / Bingham 122
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 22 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 067 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
d. STREET ADDRESS (If rural, give location) 115 Lilac St.

3. NAME OF DECEASED (Type or Print) a. (First) Myrtle b. (Middle) Adams c. (Last) Nebeker

4. DATE OF DEATH (Month) (Day) (Year) August 13, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 29, 1888

9. AGE (In years last birthday) 79
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Franklin, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Chaddwick
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Loretta Neely
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-32-4153 B

17. INFORMANT'S OWN SIGNATURE Emily Butler ADDRESS Blackfoot, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 352X Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Left Hemiplegia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 22, 19 66, *to* August 13, 19 67, *that I last saw the deceased alive on* Aug. 13, 19 67 *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 360 A. Millard (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED Aug. 16, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 16, 1967

24c. NAME OF CEMETERY OR CREMATORY grove city cemetery

24d. LOCATION (City, town, or county) Blackfoot, (State) Idaho

DATE REC'D BY LOCAL REG. 8-18-67

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER John C. Sandberg John C. Sandberg LICENSE NO. E 280

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3395
Local Reg. No. 96
Reg. Dist. No. 601

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 21 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham 130
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 30 yrsa
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) U.P. Railroad 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 061
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Reservation)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Francis
b. (Middle) Edgar
c. (Last) Pizoka

4. DATE OF DEATH (Month) (Day) (Year) August 15, 1967

5. SEX Male
6. COLOR OR RACE Am. Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Oct. 4, 1931
9. AGE (In years last birthday) 35 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Blackfoot, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Davis Pizoka — BIRTHPLACE Ft. Hall, Idaho
14. MOTHER'S MAIDEN NAME Abbie Stone Blackhawk — BIRTHPLACE Ft. Hall, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) Navy-
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Lurinda I. Ingauranya — ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

802 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple fractures of skull — INTERVAL BETWEEN ONSET AND DEATH Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Struck by train while crossing or walking on or along railroad tracks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 1 Railroad right of way 10
21c. (CITY, TOWN, OR TOWNSHIP) 13 South of Blackfoot — (COUNTY) 060 Bingham — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 15, 1967 1:10a m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Struck by train while crossing or walking on (railroad tracks

22. *I hereby certify that I attended the deceased from* 2 *19__, to ____, 19__, that I last saw the deceased* ~~alive on~~ Dead *, 19__, and that death occurred at* 1:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE Carl Staby — (Degree or title) 583 Coroner, Bingham County, 4
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED Aug. 16, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE August 17, 1967
24c. NAME OF CEMETERY OR CREMATORY Gibson Cemetery
24d. LOCATION (City, town, or county) Blackfoot, Idaho (State)

DATE REC'D BY LOCAL REG. 8-18-67
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER John C. Sandberg — LICENSE NO. E-280
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3396
Local Reg. No. 97
Reg. Dist. No. 601

RECEIVED AUG 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): U.P.Railroad (Reservation)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Nevada 29
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Owyhee (Duck Valley Reservation)
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Hilman
b. (Middle): 000
c. (Last): Harney

4. DATE OF DEATH: August 15, 1967

5. SEX: Male

6. COLOR OR RACE: Am. Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: May 30,1937

9. AGE (In years last birthday): 30
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Owyhee, Nevada

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Weldon Harney
BIRTHPLACE: Owyhee, Nevada

14. MOTHER'S MAIDEN NAME: Elsie Villard
BIRTHPLACE: Owyhee, Nevada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): About 2 months

16. SOCIAL SECURITY NO.: 519-34-7548

17. INFORMANT'S OWN SIGNATURE:
ADDRESS: Owyhee, Nevada

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushed Head — INTERVAL BETWEEN ONSET AND DEATH: Inst.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Struck by train while crossing or walking on or along railroad tracks.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Railroad right of way, South of Blackfoot

21c. (CITY, TOWN, OR TOWNSHIP) 060 **(COUNTY)** Bingham **(STATE)** Idaho

21d. TIME OF INJURY (Month) Aug. (Day) 15, (Year) 1967 (Hour) 1:10 pm

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Struck by train while crossing or wlaking on railroad tracks

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased* ~~alive~~ Dead, 19____, *and that death occurred at* 1:10a *m., from the causes and on the date stated above.*

23a. SIGNATURE: Carl Staley
(Degree or title): 583 Coroner, Bingham County
23b. ADDRESS: Blackfoot, Idaho.
23c. DATE SIGNED: Aug. 16,1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Removal
24b. DATE: Aug. 8-16-1967
24c. NAME OF CEMETERY OR CREMATORY: Owyhee Cemetery
24d. LOCATION (City, town, or county): Owyhee, (State) Nevada

DATE REC'D BY LOCAL REG.: 8-18-67
REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: John C. Sandberg, John C Sandberg
LICENSE NO.: E-280
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3397
Local Reg. No. 180
Reg. Dist. No. 600

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 061
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 701 Curtis St.

3. NAME OF DECEASED (Type or Print)
a. (First): ALVIN
b. (Middle): DUBOIS
c. (Last): JUST

4. DATE OF DEATH (Month) (Day) (Year): August 19, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: December 19, 1900
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James J. Just — BIRTHPLACE: Blackfoot, Idaho
14. MOTHER'S MAIDEN NAME: Crilla Carson — BIRTHPLACE: Iona, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-26-3721
17. INFORMANT'S OWN SIGNATURE: Franklin J. Just — ADDRESS: Idaho Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction Menestry

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Precordial Pain - 5 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-14, 1967, *to* August 19, 1967, *that I last saw the deceased alive on* August 19, 1967, *and that death occurred at* 3:15 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 360 [signature] M.D. 1
23b. ADDRESS: Blackfoot, Id;aho
23c. DATE SIGNED: August 21, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: August 23, 1967
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: Aug. 24, 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: John C. Sandberg — LICENSE NO.: E-280

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3398
Local Reg. No. 101
Reg. Dist. No. 601

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061 3-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley
c. LENGTH OF STAY (in this place) 48hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Texas 44
b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) San Beneto
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Pablo
b. (Middle)
c. (Last) Alvarez

4. DATE OF DEATH (Month) Aug (Day) 22 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Devorced 4
8. DATE OF BIRTH Oct 18 1912
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Los Fresnos, Texas
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Benito Alvarez — BIRTHPLACE Mexico
14. MOTHER'S MAIDEN NAME Librado Martinez — BIRTHPLACE Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, not or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 458-01 9018
17. INFORMANT'S OWN SIGNATURE Ed Lutesie Pena — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Insufficiency — INTERVAL BETWEEN ONSET AND DEATH Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary heart disease
DUE TO (c) Thrombosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Shelley (COUNTY) Bingham (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* I did not see victim alive, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Carl Staley 583 Coroner 4 (Degree or title)
23b. ADDRESS 321 E. Walker Blackfoot
23c. DATE SIGNED 8-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 8-23-67
24c. NAME OF CEMETERY OR CREMATORY Benito
24d. LOCATION (City, town, or county) San Benito (State) Texas

DATE REC'D BY LOCAL REG. Aug. 25, 1967
REGISTRAR'S SIGNATURE Jack A. Jelke DR
25. EMBALMER Lloyd M. Nalder Lloyd M. Nalder
LICENSE NO. E-275
FIRM NAME: Nalder Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-8561

BIRTH NO.

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3399
Local Reg. No. 104
Reg. Dist. No. 600

SEP 11 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Blackfoot
d. STREET ADDRESS (If rural, give location) Route #1, Rising River

3. NAME OF DECEASED (Type or Print)
a. (First) Infant
b. (Middle)
c. (Last) Quezada

4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1967

5. SEX female

6. COLOR OR RACE Mexican

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH Aug. 25, 1967

9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR Months 0 Days 0 — IF UNDER 24 HRS. Hours 1 Min. 40

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Blackfoot, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Sixto Quezada — BIRTHPLACE Texas

14. MOTHER'S MAIDEN NAME Gualdalupe Mendoza — BIRTHPLACE Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Sixto Quezada — ADDRESS Blackfoot, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

750X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congenital deformity of

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Skull and brain (anceptoly)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 1 hour

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 11:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE Howard Packham 404 (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED 8-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8-26-67

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) (State) Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG. Aug. 30, 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Howard Packham

LICENSE NO. E-338

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Howard Packham Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3400
Local Reg. No. 102
Reg. Dist. No. 600

BIRTH NO.

SEP 11 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061 — c. LENGTH OF STAY (in this place): 10 days
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 339

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Bingham 061
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 105 Maple St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HANNAH	L.	PECK	August 26 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	divorced 4	January 2, 1881	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	Home	Bloomington, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Neil P. Nelson	Denmark	Elsa M. Hansen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-07-4522	Walter H. Peck	Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5795 Bowel obstruction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Multiple fractures, lacerations etc.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Decom

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Arterio sclerosis and Cardiac Decompensation 10y

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19 56, *to* Augsut 26, 1967, *that I last saw the deceased alive on* August 26, 1967, *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 404	M.D.	Blackfoot, Idaho	August 30, 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	August 30, 67	Grove City Cemetery	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 1, 1967	Dorothy J. Jones	L. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of usual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3401
Local Reg. No. 103
Reg. Dist. No. 601

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
c. LENGTH OF STAY (in this place): minutes 505
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 191 3 miles north Blackfoot 060

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print)
a. (First): STEPHEN
b. (Middle): GEORGE
c. (Last): GHEEN

4. DATE OF DEATH (Month) (Day) (Year): August 30, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: July 29, 1909
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Frontier, Wyoming
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William J. Gheen — BIRTHPLACE: Ogden, Utah
14. MOTHER'S MAIDEN NAME: Mary Winn — BIRTHPLACE: Nephi, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): World War II 4
16. SOCIAL SECURITY NO.: 529-05-7172
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8120

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Fractured cervical spine — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Multiple fractures and lacerations
DUE TO (c): Struck by pickup truck

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 191 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Blackfoot, 13 Bingham 061 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): August 30 1967 1:30 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Steped out of truck and walked in fromt of pickup. Failed to look.

22. *I hereby certify that I attended the deceased from* August 30, 1967, *to* ~~xxxxxxxxxxxx, 19xx that I last saw the deceased alive on xxxxxxxxxxxx, 19xx~~, *and that death occurred at* 1:30p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Carl Stoltz
583 (Degree or title): ~~Coroner~~, Bingham county 4
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: August 31, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial 1
24b. DATE: Sept 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Sept. 1, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: E. Dean Hill
LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 20 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 16 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

APR 8 1968

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3402
Local Reg. No. 32
Reg. Dist. No. 410

BIRTH NO.

RECEIVED AUG 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 070 Blaine 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Camp ground-1½ mi. No. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1734 Brooklawn

3. NAME OF DECEASED (Type or Print)
a. (First): Glen
b. (Middle): Allison
c. (Last): Coppinger

4. DATE OF DEATH (Month) (Day) (Year): August 1, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Mar. 9, 1929
9. AGE (In years last birthday): 38 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor-builder 11
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Cortez, Colorado
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Glen P. Coppinger — BIRTHPLACE: Colorado
14. MOTHER'S MAIDEN NAME: Anna Ruth Hildreth — BIRTHPLACE: Arizona

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Larry Coppinger — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 981X Gun shot wounds (5) — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 3
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Campground 12
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 070 **(STATE)**: North of Sun Valley Blaine Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. Scott Earle MD Coroner 583 4
23b. ADDRESS: Sun Valley, Idaho
23c. DATE SIGNED: 8/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/5/67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Aug 10 67
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Ruth Bird — LICENSE NO. E-373

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev. Ca B.W.

FIRM NAME: Alden-Waggoner Chapel

AUG 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 1 7 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3403
Local Reg. No. 33
Reg. Dist. No. 410

RECEIVED
AUG 11 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 070 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hosp. 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 070
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
d. STREET ADDRESS (If rural, give location): ######

3. NAME OF DECEASED (Type or Print)
a. (First): ANNA
b. (Middle): M
c. (Last): McKAY

4. DATE OF DEATH (Month) (Day) (Year): Aug. 2, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH:
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unk
BIRTHPLACE: unk
14. MOTHER'S MAIDEN NAME: unk
BIRTHPLACE: unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-22-3126
17. INFORMANT'S OWN SIGNATURE: Geo E. McKay
ADDRESS: Hailey, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/2, 1967 *to* 8/2, 1967 *that I last saw the deceased alive on* 8/2, 1967, *and that death occurred at* 10:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Martin Peterson M.D. 752 (Degree or title)
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: 8/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: Aug 10/67
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Ruth Bird
LICENSE NO.: E 373

Federal Security Agency
United States Public Health Service

Form DH-63021 for CBW

FIRM NAME: Bird Funeral Home, Hailey

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 24 1967

SEP 19 1967

DEC 22 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3404
Local Reg. No. 34
Reg. Dist. No. 410

RECEIVED AUG 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 030 000
b. CITY OR TOWN: Sun Valley
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Sun Valley Hosp. 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 13 Idaho
b. COUNTY: 000
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Ramen b. (Middle) c. (Last) Arrate

4. DATE OF DEATH: (Month) (Day) (Year) Aug. 4, 1967

5. SEX: male
6. COLOR OR RACE: Basque
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced 4
8. DATE OF BIRTH: Au. 17, 1901
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: livestock
11. BIRTHPLACE (State or foreign country): Spain
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Leocarde Arrate — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Carmen Egea — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Julian Arrate — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4208

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Mesenteric embolism (Presumed) (Suspected) — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Atrial fibrillation & arterio-sclerotic heart disease — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: April 67
19b. MAJOR FINDINGS OF OPERATION: Mesenteric embolus
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1, 1967, *to* death, 19___, *that I last saw the deceased alive on* Aug 4, 1967, *and that death occurred at* 6:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] 151 (Degree or title) MD 1
23b. ADDRESS: Sun Valley, Idaho
23c. DATE SIGNED: 8/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 8/5/67
24c. NAME OF CEMETERY OR CREMATORY: Catholic 3
24d. LOCATION (City, town, or county) (State): Winnemucca, Nevada

DATE REC'D BY LOCAL REG.: Aug 10/67
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird — LICENSE NO.: E373
FIRM NAME: Bird Funeral Home, Hailey, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021 Rev. Ker B.W.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record-typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3405
Local Reg. No. 36
Reg. Dist. No. 410

BIRTH NO.

AUG 23 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 070 Blaine County 304

b. CITY OR TOWN: Sun Valley

c. LENGTH OF STAY (in this place): 4 days 036

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY 101: Bonneville

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho

d. STREET ADDRESS (If rural, give location): 2246 South Higbee

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Marvin	Edward	Hillman	Aug. 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	10 Sept. 1920	46		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman 24	Aluminum Sales	Shelley, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Edward Hillman		Mary Harker Hillman	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes entered-19 Feb. 1945 4	529-14-9957	X Mary Hillman	Idaho Falls Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/3, 19 67 *to* 8/6, 19 67, *that I last saw the deceased alive on* 8/6, 19 67, *and that death occurred at* 12:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Warren Larsen	752 M.D.	Sun Valley Idaho	8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 9, 1967	Hillcrest Cemetary	Shelley, Bingham, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 22 67	Robert H. Wright	Buck Bird	E 373

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev 6-63N

FIRM NAME: Bird Funeral Home

AUG 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 29 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 1 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3406
Local Reg. No. 37
Reg. Dist. No. 410

Certificate of Death

RECEIVED
AUG 23 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 070
a. COUNTY Blaine County 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Copper Basin
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Copper Basin 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 227 5th Ave. E.

3. NAME OF DECEASED (Type or Print)
a. (First) Charles
b. (Middle) M.
c. (Last) Heppler

4. DATE OF DEATH (Month) (Day) (Year) August 14, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Feb. 4, 1884
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Richfield, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Andrew Heppler — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME unknown — BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-7774
17. INFORMANT'S OWN SIGNATURE Mrs Tess Clark — ADDRESS Twin Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion (suspected) — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 1:15 p m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 151 MD. (Degree or title)
23b. ADDRESS Sun Valley Idaho
23c. DATE SIGNED 8/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Aug. 17, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Aug 22/67
REGISTRAR'S SIGNATURE Robert H. Wright
25. EMBALMER [signature]
LICENSE NO. E 343

Federal Security Agency
United States Public Health Service
Form DH-63021 Rev C.B.W.
FIRM NAME: WHITE MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3407
Local Reg. No. 27
Reg. Dist. No. 410

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 070 Blaine
b. CITY OR TOWN Sun Valley
c. LENGTH OF STAY IN (this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 070 Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bellevue
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) "R"
b. (Middle) "B"
c. (Last) McClure

4. DATE OF DEATH (Month) (Day) (Year) August 16, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH March 4, 1910

9. AGE (In years last birthday) 57
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Bellevue

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME H. M. McClure
BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Nellie May Collins
BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) 4-3-42 3-3-46

16. SOCIAL SECURITY NO. 546-01-1007

17. INFORMANT'S OWN SIGNATURE E R McClure
ADDRESS Bellevue, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) C. B. C.
INTERVAL BETWEEN ONSET AND DEATH 10 d.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) R. H. D. 30 y

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-1 1967 *to* 8-16 1967, *that I last saw the deceased alive on* 8-14 1967, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE [illegible] 455 (Degree or title) MD

23b. ADDRESS Sun Valley Idaho

23c. DATE SIGNED 8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 19 67

24c. NAME OF CEMETERY OR CREMATORY Bellevue Cemetery

24d. LOCATION (City, town, or county) Bellevue (State) Idaho

DATE REC'D BY LOCAL REG. Sept-9/67

REGISTRAR'S SIGNATURE Robert H. Wright

25. EMBALMER Keith Bird LICENSE NO. E 373

FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-630 (Rev. 12-53)

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

NOV 10 1967

DEC 29 2000

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3408
Local Reg. No. 38
Reg. Dist. No. 410

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 070 Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Magic Reservior Dam
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Reservior 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 638 4th Ave. E.

3. NAME OF DECEASED (Type or Print)
a. (First) Sidney
b. (Middle) L.
c. (Last) Craig

4. DATE OF DEATH (Month) (Day) (Year) August 20, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Nov. 28, 1893
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) insurance agent 24
10b. KIND OF BUSINESS OR INDUSTRY Craig Ins. Agency
11. BIRTHPLACE (State or foreign country) Lake City, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hiram P. Craig — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Elizabeth — BIRTHPLACE Topeka, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-36-8948
17. INFORMANT'S OWN SIGNATURE X Bertha Craig — ADDRESS Twin Falls, Ida.

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Artery occlusion — INTERVAL BETWEEN ONSET AND DEATH 5 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive, *19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 10:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 386 (Degree or title)
23b. ADDRESS 18 Box 68 Shoshone Idaho
23c. DATE SIGNED 8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Aug. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Aug 27/67
REGISTRAR'S SIGNATURE Robert H. Wright
25. EMBALMER [signature]
LICENSE NO. 343

Federal Security Agency
United States Public Health Service
Form DH-63021 Rev 6 B W
FIRM NAME: WHITE MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3409
Local Reg. No. 39
Reg. Dist. No. 410

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 31 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 070 Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
c. LENGTH OF STAY (in this place) 5 dys. 305
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blaine Co. Hospital 037

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 070 b. COUNTY Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
d. STREET ADDRESS (If rural, give location) 219 2nd Ave. North

3. NAME OF DECEASED (Type or Print)
a. (First) GERTRUDE b. (Middle) ANNA c. (Last) McCLURE

4. DATE OF DEATH (Month) (Day) (Year) Aug. 27, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH May 14, 1883
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY ho me
11. BIRTHPLACE (State or foreign country) Fort Wayne, Inda.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unk Draker BIRTHPLACE UNK
14. MOTHER'S MAIDEN NAME Sylvia Unk BIRTHPLACE UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Harold R. McClure ADDRESS Hailey

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 mo. several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1964, 19__, *to* Aug 27, 1967, *that I last saw the deceased alive on* Aug 27, 1967, *and that death occurred at* 2:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 402 (Degree or title) 1
23b. ADDRESS Box 37 Hailey Idaho
23c. DATE SIGNED 8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 1, 67
24c. NAME OF CEMETERY OR CREMATORY Hailey Cemetery
24d. LOCATION (City, town, or county) (State) Hailey, Idaho

DATE REC'D BY LOCAL REG. Aug 30/67
REGISTRAR'S SIGNATURE Robert H. Wright
25. EMBALMER Keith Bird [signature]
LICENSE NO. E-373

Federal Security Agency
United States Public Health Service

Form DH-63021 per C.B.W.

FIRM NAME: Bird Funeral Home, Hailey, Ida

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signature of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3410
Local Reg. No. 410
Reg. Dist. No. 410

BIRTH NO.

RECEIVED AUG 31 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 010 Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
LENGTH OF STAY (in this place) 24 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blaine County Hospital 037

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 010 b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
d. STREET ADDRESS (If rural, give location) Route # 3

3. NAME OF DECEASED (Type or Print) a. (First) Thomas b. (Middle) Jewell c. (Last) Cagle
4. DATE OF DEATH (Month) (Day) (Year) August 29, 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH August 26, 1898
9. AGE (In years last birthday) 78 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Cortage, Missouri
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME Willie Frank Cagle BIRTHPLACE UNK.
14. MOTHER'S MAIDEN NAME Lowlla Myers BIRTHPLACE Missouri
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 42 2177
17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Meridian, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: several yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Sclerotic Heart Dis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-5, 1924, *to* 8-29, 1967, *that I last saw the deceased alive on* 12 Noon 8-29-67, *and that death occurred at* 12:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Alden M Packer M.D. (Degree or title) 402
23b. ADDRESS Box 37 Hailey Idaho
23c. DATE SIGNED 8-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Aug. 29, 67
24c. NAME OF CEMETERY OR CREMATORY Meridian Cemetery
24d. LOCATION (City, town, or county) Meridian (State) Idaho

DATE REC'D BY LOCAL REG. Aug 30 67
REGISTRAR'S SIGNATURE Robert H. Wright
25. EMBALMER Keith Bird. LICENSE NO. E 373
FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021 Rev 1-57

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 29 1999

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3411
Local Reg. No. 352
Reg. Dist. No.

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 080 Boise
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place): 68 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clear Creek and Grimes Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: 035 Grays Harbor
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
d. STREET ADDRESS (If rural, give location): 1712 Bay Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Andrew b. (Middle) c. (Last) Davidson

4. DATE OF DEATH: (Month) (Day) (Year) August 6, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Aug. 8, 1881

9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Coalfield, Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Davidson — BIRTHPLACE: Scotland

14. MOTHER'S MAIDEN NAME: Janet Graham — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: No.

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Hazel Sinclair Aberdeen Wash.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Richard H. Hanby 583 (Degree or title) Coroner

23b. ADDRESS: Crouch Idaho

23c. DATE SIGNED: 8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-9-67

24c. NAME OF CEMETERY OR CREMATORY: Clear Creek

24d. LOCATION (City, town, or county) (State): Rural Boise, Idaho

DATE REC'D BY LOCAL REG.: 9/1/67

REGISTRAR'S SIGNATURE: Henrietta Penrod

25. EMBALMER: Daniel G. Gibson

LICENSE NO.: E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

FEB 12 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3412
Local Reg. No. 99
Reg. Dist. No. 110

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 091 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
c. LENGTH OF STAY IN (this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 802 N. 5th, Cabin # 1 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 090
b. COUNTY Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hope
d. STREET ADDRESS (If rural, give location) Spring Creek Road

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Samuel	Sherman	Pierce	June 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	October 14, 1884	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Own farm	Tipton, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Alonzo Pierce	Ohio	Eliza Jane Young	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	--	518-05-2812	X Nancy M Singleton	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease — year
DUE TO (c) Arteriosclerotic Heart Disease — year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3/17, 1961, *to* 6/26, 1967, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	[illegible] address	8/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 1, 1967	Clark Fork Cemetery	Clark Fork Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 21, 1967	[signature]	Barry D. Nelson	E-455

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3413
Local Reg. No. 100
Reg. Dist. No. 110

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 091 Bonner 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
c. LENGTH OF STAY (in this place) 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 091
b. COUNTY Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
d. STREET ADDRESS (If rural, give location) 229 Church Street

3. NAME OF DECEASED (Type or Print)
a. (First) Sophie
b. (Middle) Matilda
c. (Last) Bowenkamp

4. DATE OF DEATH (Month) (Day) (Year) August 1, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 28, 1888
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: No record — BIRTHPLACE: No record
14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 518-32-0395A
17. INFORMANT'S OWN SIGNATURE: Gilbert C. Norlin — ADDRESS

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1-2 Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — Years
DUE TO (c) Arteriosclerotic Head disease — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes — 1 year

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 20, 1958, *to* Aug 1, 1967, *that I last saw the deceased alive on* July 26, 1967, *and that death occurred at* 7:20 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Fannie Sieman 471 (Degree or title) 1
23b. ADDRESS
23c. DATE SIGNED: 8/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint, Idaho

DATE REC'D BY LOCAL REG.: Aug 31, 1967
REGISTRAR'S SIGNATURE: Phyllis G. Tibbetts
25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3414
Local Reg. No. 97
Reg. Dist. No. 110

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 091 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 13 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 091 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print): a. (First) Ernest; b. (Middle) Arthur; c. (Last) Swanson

4. DATE OF DEATH: (Month) August (Day) 3, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: June 10, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Seattle, Washington
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arvid Swanson — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Lula Magnuson — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 518-05-2377
17. INFORMANT'S OWN SIGNATURE: Lula Anderson — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 9 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Barry D. Nelson 583 (Degree or title): Coroner
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 8/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Aug. 14, 1967
REGISTRAR'S SIGNATURE: Phyllis Y. Tibbetts
25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3415
Local Reg. No. 95
Reg. Dist. No. 110

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 090 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Sandpoint
c. LENGTH OF STAY (in this place) 1 1/2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 090
b. COUNTY Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint - Rural
d. STREET ADDRESS (If rural, give location) N. Baldy Road next to city dump

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Zygmunt		Kempinski	August 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Sept. 3, 1907	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Caretaker - watchman 06	general labor	Pittsburg, Pennsylvania	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter Kempinski	Poland	Vertmatowitz	Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
unknown	--	174-14-1697	Personal papers	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harry L. Nelson 583 Coroner 4	Sandpoint, Idaho	8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 8, 1967	Pinecrest Cemetery	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 14, 1967	Phyllis M. Tibbetts	Dale G. Coffelt	E-501

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3416
Local Reg. No. 98
Reg. Dist. No. 110

Certificate of Death

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 091 Bonner 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 40 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 091 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 630 Superior

3. NAME OF DECEASED (Type or Print)
a. (First): Sidney
b. (Middle): M.
c. (Last): Cramer

4. DATE OF DEATH (Month) (Day) (Year): August 5, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 18, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Semi-retired Plumber & electrician
10b. KIND OF BUSINESS OR INDUSTRY: 81
11. BIRTHPLACE (State or foreign country): Peshtigo, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William A. Cramer — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Elizabeth Slatcher — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 519-36-3186
17. INFORMANT'S OWN SIGNATURE: Belva Haywoodth — ADDRESS: 321 S. Lavina

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Sudden myocardial death — INTERVAL BETWEEN ONSET AND DEATH: second

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Coronary artery disease — two-3 month
DUE TO (c): Arteriosclerotic Heart disease — year

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 4, 1967, *to* Aug 5, 1967, *that I last saw the deceased alive on* Aug 4, 1967, *and that death occurred at* 9:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Fayette Seemann 471
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Aug 21, 1967
REGISTRAR'S SIGNATURE: Fayette Y. Tibbetts
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3417
Local Reg. No. 90
Reg. Dist. No. 110

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 090 Bonner 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 19.5 mi. N. Priest River
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hiway #57 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 090 b. COUNTY Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Priest River
d. STREET ADDRESS (If rural, give location) Rt. 5

3. NAME OF DECEASED (Type or Print)
a. (First) Weldon b. (Middle) Clifford c. (Last) Warren

4. DATE OF DEATH (Month) (Day) (Year) August 6 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: April 27 1949
9. AGE (In years last birthday): 18 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): Newport, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Weldon Warren — BIRTHPLACE: Washington
14. MOTHER'S MAIDEN NAME: Wynona Raine — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Weldon D. Warren — ADDRESS: Rt. 5 Priest River Id

8254

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Extreme accidental trauma — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Massive abdominal hemorhage
DUE TO (c) Fractures, multiple and extreme

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hiway 57 20 mi. N 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 Priest River (COUNTY) 090 Bonner (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 8, 1967 5:30AM
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2
21f. HOW DID INJURY OCCUR? One car accident

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Barry D. Nelson 583 (Degree or title) Coroner 4
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 8-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 8/9/67
24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
24d. LOCATION (City, town, or county) (State): Priest River Idaho

DATE REC'D BY LOCAL REG.: Aug 14 1967
REGISTRAR'S SIGNATURE: Phyllis Y. Tibbetts
25. EMBALMER: R. D. Sherman — LICENSE NO.: QL749

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sherman Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3418
Local Reg. No. 101
Reg. Dist. No. 110

RECEIVED SEP 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 091 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 091 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
d. STREET ADDRESS (If rural, give location) 311 Oak Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Edna	L.	Armfield	August 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	June 8, 1892	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper 19	Office work	North Carolina	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John L. Woodruff	N. Carolina	Julia Brannock	N. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	--	536-22-0144A	Vera Earl Williams	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio Vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 1, 1967, *to* Aug 10, 1967, *that I last saw the deceased alive on* Aug 8, 1967, *and that death occurred at* 9:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred E. Mauerman 327	MD	Sandpoint, Idaho	8-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Aug. 13, 1967	Forest Lawn	Glendale, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 21, 1967	Phyllis Y. Willetts	Dale G. Coffelt	E-501

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 27 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3419
Local Reg. No. 102
Reg. Dist. No. 110

Certificate of Death

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 091 Bonner 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (In this place): 8 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 090
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ponderay
d. STREET ADDRESS (If rural, give location): Box 136 - in village limits

3. NAME OF DECEASED (Type or Print)
a. (First): Helen
b. (Middle): Elizabeth
c. (Last): Bingaman

4. DATE OF DEATH (Month) (Day) (Year): August 14 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 16, 1890
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jerris Dewey Pellett — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Annie Rich — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 533-12-5775
17. INFORMANT'S OWN SIGNATURE: Walter L Bingaman — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

442X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio vascular renal disease — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1966, 19__, *to* Aug 14, 1967, *that I last saw the deceased alive on* Aug 13, 1967, *and that death occurred at* 1:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Fred E Maurer 327 (Degree or title) MD
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 8-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 19, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint, Idaho

DATE REC'D BY LOCAL REG.: Aug. 21, 1967
REGISTRAR'S SIGNATURE: Phyllis Y. Pilchette
25. EMBALMER: L. G. Moon, Jr.
LICENSE NO.: E-405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3420
Local Reg. No. 103
Reg. Dist. No. 110

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 09 Bonner 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
LENGTH OF STAY (in this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 09 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
d. STREET ADDRESS (If rural, give location) 1202 Oak Street

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) August 18, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Oct. 12, 1877
9. AGE (In years last birthday) 89 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 17
10b. KIND OF BUSINESS OR INDUSTRY Lumber
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew Smith BIRTHPLACE U.S.A.
14. MOTHER'S MAIDEN NAME Almira Howe BIRTHPLACE U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 517-01-0839
17. INFORMANT'S OWN SIGNATURE Everett D. Smith ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4427

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cardio Vascular Renal — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) disease Chronic — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1958 *to* Aug, 1967, *that I last saw the deceased alive on* Aug 17, 1967, *and that death occurred at* 8 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 382 (Degree or title) J. Munson MD
23b. ADDRESS Sandpoint, Idaho
23c. DATE SIGNED 8-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY Pinecrest Cemetery
24d. LOCATION (City, town, or county) Sandpoint (State) Idaho

DATE REC'D BY LOCAL REG. Aug 25, 67
REGISTRAR'S SIGNATURE Fayette G. Tibbetts
25. EMBALMER L. G. Moon, Jr.
LICENSE NO. E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Thompson

RECEIVED

SEP 11 1967

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3421
Local Reg. No. 115
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 090 Bonner 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Careywood
c. LENGTH OF STAY (in this place) 10-days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Star Rt. Sandpoint 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Gladys
b. (Middle)
c. (Last) Newsum

4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Mar. 17, 1894
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Consultant 19
10b. KIND OF BUSINESS OR INDUSTRY Calif. Correctional
11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Lincoln E. Spencer — BIRTHPLACE Michigan
14. MOTHER'S MAIDEN NAME Mary Jane Nevins — BIRTHPLACE Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) War Two 4
16. SOCIAL SECURITY NO. 067-09-0114
17. INFORMANT'S OWN SIGNATURE X E. E. Spencer — ADDRESS Post Falls, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1950

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Adrenal Gland — INTERVAL BETWEEN ONSET AND DEATH 3 months.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION August 7, 1967
19b. MAJOR FINDINGS OF OPERATION Carcinoma adrenal on left with metastases to liver
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 6 *19*67 *to* August 25, *19*67, *that I last saw the deceased alive on* August 17, *19*67, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE E. E. Thompson 530 (Degree or title) MD 1
23b. ADDRESS 318 Elder Building Coeur d'Alene Idaho
23c. DATE SIGNED August 30, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 80-30-67
24c. NAME OF CEMETERY OR CREMATORY Restlawn Memorial Park
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Sept. 1, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Stiplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME English Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 25 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3422
Local Reg. No. 789
Reg. Dist. No. 110

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 091 Bonner
b. CITY OR TOWN Sandpoint
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 090 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Colburn
d. STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print) a. (First) Gaylord b. (Middle) Joseph c. (Last) Crockroft

4. DATE OF DEATH (Month) (Day) (Year) August 29, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 27, 1920
9. AGE (In years last birthday) 46 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY automobile
11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Crockroft BIRTHPLACE Wisconsin
14. MOTHER'S MAIDEN NAME Pearl Harderbrook BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 474-12-8956
17. INFORMANT'S OWN SIGNATURE X Sylvia Crockroft ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchio pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Pulmonary Congestion — 6 months
DUE TO (c) hypertensive heart disease — 2 years
15 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardio sperm Edentiderophysis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-1, 1967, *to* 8-29, 1967, *that I last saw the deceased alive on* 8-24, 1967, *and that death occurred at* 8:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE 327 (Degree or title) MD
23b. ADDRESS Sandpoint, Idaho
23c. DATE SIGNED 9-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Aug. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery
24d. LOCATION (City, town, or county) Colville, Washington (State)

DATE REC'D BY LOCAL REG. Sept 15 1967
REGISTRAR'S SIGNATURE
25. EMBALMER Dale G. Coffelt
LICENSE NO. E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 21 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3423
Local Reg. No. 104
Reg. Dist. No. 110

RECEIVED SEP 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 091 Bonner 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 091 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
d. STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print)
a. (First) Elder
b. (Middle) William
c. (Last) Lawrence

4. DATE OF DEATH (Month) (Day) (Year) August 30, 1967

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Nov. 16, 1884
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Lebanon, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME No record — BIRTHPLACE No record
14. MOTHER'S MAIDEN NAME No record — BIRTHPLACE No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 536-50-4439
17. INFORMANT'S OWN SIGNATURE Laura A Cheek — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

545X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric rupture c̄

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Peritonitis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1958, *to* Aug, 1967, *that I last saw the deceased alive on* Aug 30, 1967, *and that death occurred at* 6P *m., from the causes and on the date stated above.*

23a. SIGNATURE J L Munsons 382 (Degree or title) 1
23b. ADDRESS Sandpoint Ida
23c. DATE SIGNED 9-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY Pinecrest Cemetery
24d. LOCATION (City, town, or county) Sandpoint, Idaho (State)

DATE REC'D BY LOCAL REG. Sept 7, 1967
REGISTRAR'S SIGNATURE Phyllis G Tibbetts
25. EMBALMER Dale G. Coffelt
LICENSE NO. E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3424
Local Reg. No. 253
Reg. Dist. No. 610

RECEIVED SEP 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Nursing Home 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 220
b. COUNTY Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
d. STREET ADDRESS (If rural, give location) None Given

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	GEORGE	J.	SCRBACIC	23 June 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	9 May 1890	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Farm	Yugoslavia	YugoSlavia

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	------	509-09-5430	Hospital Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1778 Metastatic carcinoma of the prostate.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS pathological fracture, right femur
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3-11-67

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
3-21-67	Metastatic carcinoma	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
/	hospital 13	Idaho Falls	Bonneville	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
3	11	67	m.		fell

22. *I hereby certify that I attended the deceased from* March 11, 19 67, *to* June 21, 19 67, *that I last saw the deceased alive on* June 21, 1967, *and that death occurred at* 2:10P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert R Bean	732 MM	1210 E. 17th Street Idaho Falls, Idaho 83401	7-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	6-27-67	Pineview Cemetery	Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 14-1967	Emma Bridges	Robert O Bean	E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3425
Local Reg. No. 23
Reg. Dist. No. 610

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 14 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenvitw Chalet 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 178 Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Dubois
d. STREET ADDRESS (If rural, give location) Birch Creek

3. NAME OF DECEASED (Type or Print) a. (First) NANCY b. (Middle) JANE c. (Last) BARE

4. DATE OF DEATH (Month) July (Day) 31 (Year) 1967

5. SEX Female
6. COLOR OR RACE EWhite
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH September 8, 1889
9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Wagoner, North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jasper Bare BIRTHPLACE North Carolina
14. MOTHER'S MAIDEN NAME Maize Sheets BIRTHPLACE North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-44-0956
17. INFORMANT'S OWN SIGNATURE Marshal Bare ADDRESS Leadore, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4438

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage with hemiplegia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive arteriosclerotic heart disease — 1½ years
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Idaho Falls, Bonneville, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. *1959, to* July, *19 67, that I last saw the deceased alive on* July 3 *19 67, and that death occurred at* 4:50 A *m., from the causes and on the date stated above.*

23. SIGNATURE X [signature] 156 (Degree or title) MD
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE August 3,1967
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) Idaho Falls (State) Idaho

DATE REC'D BY LOCAL REG. Aug 29-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Orland C. Buck
LICENSE NO. E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Dr. Edwards

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3426
Local Reg. No. 259
Reg. Dist. No. 610

BIRTH NO.

AUG 24 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 100 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Swan Valley
c. LENGTH OF STAY (If outside hospital or institution): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 100 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Swan Valley
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Avery
b. (Middle):
c. (Last): Humphrey

4. DATE OF DEATH (Month) (Day) (Year): August 3 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 31, 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Fairview, Wyoming
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas H. Weeks — BIRTHPLACE: USA
14. MOTHER'S MAIDEN NAME: Orilla Harmon — BIRTHPLACE: USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Frank F. Humphrey — ADDRESS: Swan Valley, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

410X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) RHEUMATIC HEART DISEASE, OLD ARRESTED WITH MITRAL VALVE DISEASE. (ARRHYTHMIA)

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* DIABETES MELLITUS, CHRONIC, TREATED OBESITY; CHOLELITHIASIS

INTERVAL BETWEEN ONSET AND DEATH: YEARS — SEVERAL YEARS

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NONE
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): SWAN VALLEY BONNEVILLE IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hazel L. McGaffey — HAZEL L. MC GAFFEY, M. D. CORONER
23b. ADDRESS: 2525 SOUTH BOULEVARD, IDAHO FALLS
23c. DATE SIGNED: 8/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/7/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Aug. 19-67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood — Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

67-6513 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3427
Local Reg. No. 241
Reg. Dist. No. 610

BIRTH NO.

AUG 30 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L. D. S. Hospital - I.F., Ida. 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 00
b. COUNTY: 000
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township):
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sheryl
b. (Middle): Ann
c. (Last): Yorgensen

4. DATE OF DEATH (Month) 8 (Day) 4 (Year) 67

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: 7/24/67
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 10; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Dennis Yorgensen
BIRTHPLACE: Goshen, Idaho
14. MOTHER'S MAIDEN NAME: Dorella Ann Brooks
BIRTHPLACE: Idaho Falls, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Dennis Yorgensen
ADDRESS: Shelley

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7685

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Probable septicemia — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Prematurity — 10 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-24, 1967, *to* 8-4, 1967, *that I last saw the deceased alive on* 8-4, 1967, *and that death occurred at* 7:48 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. K. Lechelt, M.D. 304
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 8/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/8/67
24c. NAME OF CEMETERY OR CREMATORY: Basalt Cemetery
24d. LOCATION (City, town, or county): Basalt-Bingham (State): Idaho

DATE REC'D BY LOCAL REG.: Aug 26-67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: L. M. Maldin
LICENSE NO.: E 275

FIRM NAME: Maldin's Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG 25 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3428
Local Reg. No. 233
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenview Chalet Rest Home 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 221
b. COUNTY Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) ELLEN
b. (Middle) McCARTHY
c. (Last) MOWRAY

4. DATE OF DEATH (Month) (Day) (Year) August 4, 1967

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH July 31, 1875
9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John McCarthy — BIRTHPLACE Ireland
14. MOTHER'S MAIDEN NAME Mary — BIRTHPLACE Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Henrietta March- Tacoma, Wash — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9037

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Oblique fracture of the neck of the left femur 6-6-67 — INTERVAL BETWEEN ONSET AND DEATH 1½ mos.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 13
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 101 **(STATE)** Idaho Falls, Bonneville, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Fall at Nursing home

22. *I hereby certify that I attended the deceased from* 3-23, 1967, *to* 8-4, 1967, *that I last saw the deceased alive on* 8-4, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 156 (Degree or title) X R Blair Edmonds [illegible] 1
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 8 Aug 67
24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery
24d. LOCATION (City, town, or county) (State) St. Anthony, Idaho.

DATE REC'D BY LOCAL REG. Aug. 17-67
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER M. D. Hansen
LICENSE NO. #-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3429
Local Reg. No. 117
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 15 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 900 S. Emerson Avenue 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 900 S. Emerson Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	MAURICE	DONALD	ADAMS	August	6	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	December 28,1918	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 21
10b. KIND OF BUSINESS OR INDUSTRY Petroleum
11. BIRTHPLACE (State or foreign country) Concordia, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Garfield Adams — BIRTHPLACE Washington, Kansas
14. MOTHER'S MAIDEN NAME Marion Lavina Osterhaut — BIRTHPLACE White Pigeon, Mich.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II 4
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mary D. Adams — ADDRESS Idaho Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Hypernephroma of right kidney — INTERVAL BETWEEN ONSET AND DEATH 6 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with metastasis of chest wall,
DUE TO (c) lungs and back.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1961, *to* 8-6-67, 19____, *that I last saw the deceased alive on* 8-3-67, 19____, *and that death occurred at* 6:00A. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 210 (Degree or title) M. D.
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE August 9,1967
24c. NAME OF CEMETERY OR CREMATORY Fort Smith National Cem.
24d. LOCATION (City, town, or county) Fort Smith (State) Arkansas

DATE REC'D BY LOCAL REG. Aug. 12-1967
REGISTRAR'S SIGNATURE [signature]
25. FUNERAL DIRECTOR [signature]
ADDRESS Idaho Idaho Falls,

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

AUG 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

SEP 15 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 1 1968

DEC 21 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

SEP 14 1983

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of Orland C. Buck Lic. No. E-250 at Idaho Falls on 8/6/67

ADDITIONAL REMARKS by Physician

Orland Clark, M.D.

State File No. 3430
Local Reg. No. 230
Reg. Dist. No. 610

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 308
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, Idaho
c. LENGTH OF STAY (in this place) 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location) 577 E 15th Street

3. NAME OF DECEASED (Type or Print)
a. (First) Bobbie
b. (Middle) Joe
c. (Last) Everitt

4. DATE OF DEATH (Month) (Day) (Year) Aug. 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 12 Feb. 1930
9. AGE (In years last birthday) 37 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 08
10b. KIND OF BUSINESS OR INDUSTRY U.S. Government
11. BIRTHPLACE (State or foreign country) Marshall, Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joe R. Everitt — BIRTHPLACE Legionville, Texas
14. MOTHER'S MAIDEN NAME Mrytle Louise Moore — BIRTHPLACE Plainview, Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 463-38-5515
17. INFORMANT'S OWN SIGNATURE X Joe R. Everitt — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

976X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) acute Gastritis
DUE TO (c) Gun shot wound abdomen 1 wk

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION July 29
19b. MAJOR FINDINGS OF OPERATION Bowel, liver, kidney injury
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT HOMICIDE (Specify) 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 00
21c. (CITY, TOWN, OR TOWNSHIP) 23 **(COUNTY)** 101 **(STATE)** Idaho Falls, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) July 29 67 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Self inflicted gun shot

22. *I hereby certify that I attended the deceased from* July 29, 1967, *to* Aug 7, 1967, *that I last saw the deceased alive on* Aug 7, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 200 (Degree or title) R. L. Hansen MD 1
23b. ADDRESS Idaho Falls, Ida
23c. DATE SIGNED 8

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Ammon City Cemetary
24d. LOCATION (City, town, or county) (State) Ammon, Bonneville, Idaho

DATE REC'D BY LOCAL REG. Aug. 14-67
REGISTRAR'S SIGNATURE Emma Bridges
25. EMBALMER Leo A. Williams — LICENSE NO. E-319

FIRM NAME: WILLIAMS' FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 39-266 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 12 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. SEP 27 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3431
Local Reg. No. 235
Reg. Dist. No. 616

BIRTH NO.

RECEIVED AUG 25 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 291 Est 20th Street

3. NAME OF DECEASED (Type or Print)
a. (First) Ernest
b. (Middle)
c. (Last) Burgie

4. DATE OF DEATH (Month) (Day) (Year) August 8 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH October 9, 1884

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Red Rock, Montana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alfred Burgie
BIRTHPLACE Switzerland

14. MOTHER'S MAIDEN NAME Anna Burnner
BIRTHPLACE Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 44 1734A

17. INFORMANT'S OWN SIGNATURE Rosie L Burgie
ADDRESS Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Chronic Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of the urinary bladder — 8 mos
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 5-11-67

19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of the Urinary Bladder

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-6-, 1967, *to* 8-8, 1967, *that I last saw the deceased alive on* 8-7-67 19, *and that death occurred at* 2130 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Warren A. Sutton 515 (Degree or title) MD

23b. ADDRESS 555 So Blvd Idaho Falls

23c. DATE SIGNED 8/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/10/67

24c. NAME OF CEMETERY OR CREMATORY Ammon Cemetery

24d. LOCATION (City, town, or county) Ammon (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 19-1967

REGISTRAR'S SIGNATURE Anna Burgess

25. EMBALMER Ralph M. Wood

LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 24 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3432
Local Reg. No. 236
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 25 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 314
b. CITY OR TOWN Idaho Falls (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 465 Highland Drive 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 100
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ucon
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DAVID	EDWARD	PHILLIPS	August 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	March 16, 1876	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer & Rancher 04	Agriculture	Ogden, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Phillips Phillips	Wales	Jane Reese	Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	Not Avail.	Gale J. Phillips	Ucon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C. V. Accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic disease
DUE TO (c) Old age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY Ooccur?
m.		

22. *I hereby certify that I attended the deceased from* July 13, 1967, *to* July 9, 1967, *that I last saw the deceased alive on* July 6, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Milton T. Rees M-D 432	Idaho Falls, Ida.	8-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/12/67	Ucon Cemetery	Ucon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 19-1967	Anna Bedgw	Jack A. Wood, Jr.	396

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED AUG 25 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3433
Local Reg. No. 232
Reg. Dist. No. 6/0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 27 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 331 b. COUNTY Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) 205 East Main

3. NAME OF DECEASED (Type or Print) a. (First) NORA b. (Middle) GUNNELL c. (Last) BRIZZEE

4. DATE OF DEATH (Month) (Day) (Year) August 9, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Sept. 27, 1884

9. AGE (In years last birthday) 82 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Wellsville, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Francis W. Gunnell — BIRTHPLACE Houghton Notingham, England

14. MOTHER'S MAIDEN NAME Esther Lewis — BIRTHPLACE Cordinganfure, Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Henry W Brizzee — ADDRESS Menan, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5844

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH 5 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Occlusion
DUE TO (c) Past C.V.D. disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
A.S.H.D. —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE W L Nielsen 390 (Degree or title) MD

23b. ADDRESS Idaho Falls

23c. DATE SIGNED 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/12/67

24c. NAME OF CEMETERY OR CREMATORY Burton Cemetery

24d. LOCATION (City, town, or county) (State) Rexburg Rt. 1, Idaho

DATE REC'D BY LOCAL REG. Aug. 17-67

REGISTRAR'S SIGNATURE Anna Bridges

25. EMBALMER Kenneth Flamm — LICENSE NO. E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-630-2

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3434
Local Reg. No. 245
Reg. Dist. No. 610

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Firth, R#1
d. STREET ADDRESS (If rural, give location) R#1

3. NAME OF DECEASED (Type or Print)
a. (First) Clarence
b. (Middle)
c. (Last) Nelson

4. DATE OF DEATH (Month) Aug (Day) 9 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan 16 1901
9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lavaside Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME & John Nelson — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Emma Louise Vickbom — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-22-8776
17. INFORMANT'S OWN SIGNATURE Delay A. Nelson — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial occlusion — INTERVAL BETWEEN ONSET AND DEATH: Thour

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Idaho Falls
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on* Aug 9, 1967, *and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 200 (Degree or title) [signature] Mos 1
23b. ADDRESS Idaho Falls, Ida
23c. DATE SIGNED 8-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE d 8-1267
24c. NAME OF CEMETERY OR CREMATORY Riverside
24d. LOCATION (City, town, or county) Firth R#1 Bingham (State) Idaho

DATE REC'D BY LOCAL REG. Aug 26 '67
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER L. M. Naider — LICENSE NO. E275

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Naider Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3435
Local Reg. No. 237
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 25 1967
Vital Statistics

1. PLACE OF DEATH
a. COUNTY 10 / Bonneville
b. CITY OR TOWN Idaho Falls
c. LENGTH OF STAY (in this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION LDS Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101 b. COUNTY Bonneville
c. CITY OR TOWN Idaho Falls
d. STREET ADDRESS (If rural, give location) 472 7th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	AUBURN	JAY	DENNING	August 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 21, 1940	27				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Construction	Ammon, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ude Denning	Idaho	Grace Haderlie	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	Not Avail.	Jack Denning	Idaho Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis of Liver — INTERVAL BETWEEN ONSET AND DEATH Unk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* Aug 10, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.		Idaho Falls, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/14/67	Ammon Cemetery	Ammon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 19-1967	Anna Budge	Jack A. Wood, Jr.	396

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3436
Local Reg. No. 248
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 28 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 170
b. COUNTY Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Dubois
d. STREET ADDRESS (If rural, give location) Crooked Creek

3. NAME OF DECEASED (Type or Print)
a. (First) MACK
b. (Middle) STALKER
c. (Last) ELLIS

4. DATE OF DEATH (Month) August (Day) 10 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 11, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Livestock
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John D. Ellis — BIRTHPLACE: Malad, Idaho
14. MOTHER'S MAIDEN NAME: Alvira Stalker — BIRTHPLACE: Franklin, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-40-7747A
17. INFORMANT'S OWN SIGNATURE Mrs Gerald W. Thomas — ADDRESS Lubbock Texas

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of bladder — INTERVAL BETWEEN ONSET AND DEATH: 9 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. pulmonary emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 1966, *to* Aug 10, 1967, *that I last saw the deceased alive on* Aug 10, 1967, *and that death occurred at* 7:15A. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Byron Weeks 556 (Degree or title) M.D. 1
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: August 14, '67
24c. NAME OF CEMETERY OR CREMATORY: Dubois Cemetery
24d. LOCATION (City, town, or county) (State): Dubois, Clark County, Idaho

DATE REC'D BY LOCAL REG.: Aug. 29-1967
REGISTRAR'S SIGNATURE: Anna Bridger
25. EMBALMER: Orland C. Buck
LICENSE NO. E-250

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck Funeral Home

DUTIES:

SEP 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

B.T. Weeks, M.D.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3504
Local Reg. No. 252
Reg. Dist. No. 618

BIRTH NO.

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 100 Bonneville 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 5½ Miles No. of Idaho Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Interstate Hywy # 15 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 622 Lincoln

3. NAME OF DECEASED (Type or Print)
a. (First) JANICE
b. (Middle) MARIE
c. (Last) SCHUR

4. DATE OF DEATH (Month) (Day) (Year) August 11, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 7

8. DATE OF BIRTH Sept. 8, 1966

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months 11 | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Seattle, Washington

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John A. Schur — BIRTHPLACE USA

14. MOTHER'S MAIDEN NAME Robin Mesler — BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE John A. Schur — ADDRESS Idaho Falls, Idaho

18. CAUSE OF DEATH 8234

MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) SEVERE TRAUMA AND FRACTURE TO SKULL AND AMPUTATION OF RIGHT LEG BELOW KNEE

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) SINGLE CAR ACCIDENT

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. NONE

INTERVAL BETWEEN ONSET AND DEATH: IMMEDIATE

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway # 15 06

21c. (CITY, TOWN, OR TOWNSHIP) IDAHO FALLS 13 **(COUNTY)** BONNEVILLE 101 **(STATE)** IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) August 11, 1967 7:50 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? car impaled on guard rail on Highway#15

22. *I hereby certify that I attended the deceased from* August 2, 19__, *to* August 2, 19__, *that I last saw the deceased alive on* August 2, 19__, *and that death occurred at* 7:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Hazel L. McGaffey, M. D. CORONER

23b. ADDRESS 2525 South Higbee Ave

23c. DATE SIGNED 8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1

24b. DATE 8/15/67

24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. Aug 30-1967

REGISTRAR'S SIGNATURE Anna Rudges

25. EMBALMER Jack A. Wood, Jr.

LICENSE NO. 396

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal..

ADDITIONAL REMARKS by Physician.....

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Janice Marie Schur

now lying buried in Rose Hill Cemetery Cemetery, in the City or Town of Idaho Falls

County of Bonneville State of Idaho, who died on the 11 day of August, 1967, Aged - years 11 months

____ days, the cause of death being Auto accident and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Dr. Hazel McGaffey attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Railroad
private or railway conveyance

to New Tacoma Cemetery Cemetery in the City or Town of Tacoma County of _____

State of Washington to take effect upon the approval by the local board of health of the City, Town, or County of

Bonneville it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 30th day of October, A.D. 19 67.

Permit issued to:
Wood Funeral Home
Jack A. Wood, Jr., Em #396
273 North Ridge Ave.
Idaho Falls, Idaho

W. W. Benson
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of Bonneville State of Idaho, this 27 day of October, 19 67.

A. Wm. Brunt, Jr., M.D.
Health Officer

FORM BH 56-019

MAR 12 1968

TITLE 39, CHAPTER 2, SEC. 7 OF THE IDAHO CODE

"Sec. 39-211. No body shall be disinterred within the State of Idaho except upon a permit granted by the State Board of Health. The forms of disinterment permits shall be prepared by the State Board of Health. Disinterment and removal must be done under the personal supervision of a licensed embalmer, and must be done at an hour when there is the least possible exposure. Only such persons as are actually necessary shall be present. The coffin shall not be opened either at place of disinterment or place of destination, except special permit be issued by the State Board of Health. And in case of disinterment of bodies dead by reason of contagious and infectious diseases, as shown by the certificate of death given by the attending physician, the sexton and all other persons engaged in such removal or being present shall immediately thereafter change their clothing and properly disinfect their hands, head and face, provided, that such disinterment may also be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every permit: provided, also, that in case of any contagious and infectious disease where remains are to be shipped to points in other states, permission must first be obtained from the Secretary of State Board of Health of such State. The State Board of Health may also issue a special disinterment permit for legal purposes. This permit for legal purposes shall be granted only upon application of a prosecuting attorney or the Attorney General of this State, stating therein such facts which make it evident to the State Board of Health that the ends of justice require that disinterment be permitted. Such special disinterment for legal purposes shall be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every such special disinterment permit for legal purposes."

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3438
Local Reg. No. 247
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1280 Ada Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) SIMON
b. (Middle) RUEBEN
c. (Last) STEELE

4. DATE OF DEATH (Month) August (Day) 11 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 22, 1887
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer, retired 04
10b. KIND OF BUSINESS OR INDUSTRY Self employed
11. BIRTHPLACE (State or foreign country) Lake Nebagnomon Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Erick Steele — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME No record — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Russell Steele — ADDRESS Idaho Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Urinary Tract Bleeding

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Anemia
DUE TO (c) Senile Diabetes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 7/25/67
19b. MAJOR FINDINGS OF OPERATION Prostatic Hypertrophy
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* 8/11, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 436 (Degree or title) M. D.
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE August 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery
24d. LOCATION (City, town, or county) (State) Firth, Bingham County, Idaho

DATE REC'D BY LOCAL REG. Aug. 29-1967
REGISTRAR'S SIGNATURE Anna Budgeo
25. EMBALMER Orland C. Buck
LICENSE NO. E-250

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Reynolds

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 25 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3439
Local Reg. No. 232
Reg. Dist. No. 6/D

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LDS Nursing Home 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 221 Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony, Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) ELIZABETH c. (Last) ARCHIBALD BIRD

4. DATE OF DEATH (Month) (Day) (Year) August 11, 1967

5. SEX Female

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2

8. DATE OF BIRTH May 22, 1883

9. AGE (In years last birthday) 84 If under 1 year: Months / Days. If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Clarkston, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Archibald
BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Emma Loosli
BIRTHPLACE Providence, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-22-1715-D

17. INFORMANT'S OWN SIGNATURE Denice M. Parker
ADDRESS St. Anthony, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

6999

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute and Chronic Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 2 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I attended the deceased from* June, 1964, *to* Aug 11, 1967, *that I last saw the deceased alive on* Aug 9, 1967, *and that death occurred at* 2:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Byron T Webb MD 556 (Degree or title)

23b. ADDRESS 1585 So Boulevard, Idaho Falls

23c. DATE SIGNED 8/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 15 August 67

24c. NAME OF CEMETERY OR CREMATORY Teton-Newdale Cemetery

24d. LOCATION (City, town, or county) (State) Sugar City, RFD, Madison, Idaho

DATE REC'D BY LOCAL REG. Aug. 18-67

REGISTRAR'S SIGNATURE Emma Budge

25. EMBALMER M L Hansen
LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3440
Local Reg. No. 224
Reg. Dist. No. 610

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 109
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls Hospital
LENGTH OF STAY (in this place) 9 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101 b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 333 So. Holmes Avenue

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) (NMN) c. (Last) MATHEWSON

4. DATE OF DEATH (Month) August (Day) 13 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH July 8, 1865

9. AGE (In years last birthday) 102
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor, retired

10b. KIND OF BUSINESS OR INDUSTRY Building Constr.

11. BIRTHPLACE (State or foreign country) Newark, New Jersey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Mathewson
BIRTHPLACE No record

14. MOTHER'S MAIDEN NAME No record
BIRTHPLACE No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-34-3103

17. INFORMANT'S OWN SIGNATURE Harry W. Mathewson ADDRESS Ida. Idaho Falls,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4200 Arteriosclerotic Heart Disease & Decompensation — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 359 (Degree or title) M. D. 1

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED 8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE August 15, '67

24c. NAME OF CEMETERY OR CREMATORY South Side Cemetery

24d. LOCATION (City, town, or county) Pontiac (State) Illinois

DATE REC'D BY LOCAL REG. Aug. 29-1967

REGISTRAR'S SIGNATURE Anna Budgen

25. EMBALMER Orland C. Buck

LICENSE NO. E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3441
Local Reg. No. 238
Reg. Dist. No. 610

BIRTH NO.

R AUG 25 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital Ext. Care

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 208 b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rigby
d. STREET ADDRESS (If rural, give location) 100 South 2nd West Street

3. NAME OF DECEASED (Type or Print)
a. (First) ELLEN b. (Middle) ALICE 042 (NELL) c. (Last) PALMER

4. DATE OF DEATH (Month) (Day) (Year) Aug. 13, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 5, 1876
9. AGE (In years last birthday) 91 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Educator 12
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) St. Louis, Missouri.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jabez Dierden — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Mary Ada Pickles — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-54-4716
17. INFORMANT'S OWN SIGNATURE Fred D. Fisher — ADDRESS Oakland, Calif.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 18 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease 15 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 8, 1939, *to* August 13, 1967, *that I last saw the deceased alive on* August 12, 1967, *and that death occurred at* 9:30 A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE Aldon Hall 521 (Degree or title) M.D.
23b. ADDRESS Rigby, Idaho.
23c. DATE SIGNED 8/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY Pioneer
24d. LOCATION (City, town, or county) (State) Rigby, Jefferson, Idaho.

DATE REC'D BY LOCAL REG. Aug 18 1967
REGISTRAR'S SIGNATURE Anna Bredger
25. EMBALMER Bruce A. Eckersell — LICENSE NO. E-404

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Eckersell Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

MAR 1 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3442
Local Reg. No. 293
Reg. Dist. No. 6/0

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) LDS Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Iona
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPH
b. (Middle)
c. (Last) LONGHURST

4. DATE OF DEATH (Month) (Day) (Year) August 14, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH June 24, 1887

9. AGE (In years last birthday) 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 07

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Iona, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Longhurst
BIRTHPLACE USA

14. MOTHER'S MAIDEN NAME Lidia Bennett
BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. Not Avail.

17. INFORMANT'S SIGNATURE W. M. Longhurst
ADDRESS Iona, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4437

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cardiac decompensation — 6 months

DUE TO (c) Hypertensive Cardiovascular disease — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1967 *to* Aug 14, 1967, *that I last saw the deceased alive on* 8/14, 1967, *and that death occurred at* 3 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE David N. Smith, M.D. 479 (Degree or title)

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED 8/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/18/67

24c. NAME OF CEMETERY OR CREMATORY Iona Cemetery

24d. LOCATION (City, town, or county) Iona, Idaho (State)

DATE REC'D BY LOCAL REG. Aug 24-1967

REGISTRAR'S SIGNATURE Anna Bridges

25. EMBALMER Jack A. Wood, Jr.

LICENSE NO. 396

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 25 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3443
Local Reg. No. 244
Reg. Dist. No. 610

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 — 315
b. CITY OR TOWN: Idaho Falls
LENGTH OF STAY (in this place): 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 2400 South Blvd

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ANDREW	H.	KEEFER	August 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	July 22, 1889	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Developer 24	Real Estate	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J.H. Keefer	USA	Margaret Yoe	USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 09 2212	Eliza Keefer	Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Head of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1965	Carcinoma Pancreas	YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 1962 *to* ____, 19____, *that I last saw the deceased alive on* Aug 15, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
K. L. Hansen MD		Idaho Falls, Ida	8/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/17/67	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 28-1967	Emma Budge	Jack A. Wood, Jr.	396

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 24 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3444
Local Reg. No. 251
Reg. Dist. No. 610

BIRTH NO.

REGISTERED SEP 5 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 101 Bonneville

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

c. LENGTH OF STAY (in this place): 51 years

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 108

b. COUNTY: Bonneville

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Idaho Falls

d. STREET ADDRESS (If rural, give location): 1 1/2 miles north Taylorville School

3. NAME OF DECEASED (Type or Print)

a. (First): WILLIAM

b. (Middle): ALEXANDER

c. (Last): HENRIE

4. DATE OF DEATH: (Month) August (Day) 15 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: February 21, 1891

9. AGE (In years last birthday): 76

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian, retired 01

10b. KIND OF BUSINESS OR INDUSTRY: Public Park

11. BIRTHPLACE (State or foreign country): Pleasant Grove, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Henrie

BIRTHPLACE: Aberdeen, Scotland

14. MOTHER'S MAIDEN NAME: Annie Thompson

BIRTHPLACE: Aberdeen, Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 519-07-4798

17. INFORMANT'S OWN SIGNATURE: Edna Henrie

ADDRESS: Idaho Falls, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3020

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Cardiac failure

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Pulmonary emphysema

DUE TO (c): Chronic bronchitis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 6:05P m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. K. Nielsen 390 (Degree or title) M.D.

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: August 18, '67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Aug 29-1967

REGISTRAR'S SIGNATURE: Anna Burgess

25. EMBALMER: Orland C Buck

LICENSE NO.: E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 6 1967
SEP 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

Leo. Nielsen

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Void

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 30 1967 Bureau of Vital Statistics

State File No. 3445
Local Reg. No. 244
Reg. Dist. No. 61 D

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN Idaho Falls (If outside corporate limits, write RURAL and give township)
d. FULL NAME OF HOSPITAL OR INSTITUTION L.D.S. Hospital 042
STAY (in this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 100 Bonneville
c. CITY OR TOWN Ucon, Idaho
d. STREET ADDRESS (If rural, give location) Gen Del.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CLYDE	MILO	JORGENSEN	Aug 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
male	white	Widowed 2	Oct 29, 1899	67	9	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer & Laborer 04		Oxford, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Jorgenson	Denmark	Margaret Andrus	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-07-5096	X Donald Jorgenson	Ucon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

5271

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary Emphysema — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cor pulmonale

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-15, 1964, *to* 8/19, 1967, *that I last saw the deceased alive on* 8/19, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Leo A Williams 546 (Degree or title)	Idaho Falls, Idaho	8/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 24, 1967	Monarch Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 26, 1967	Anna Bridges	Leo A Williams	E-319

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Williams Funeral Home

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Clyde Milo Jorgensen

now lying buried in Monarch Memory Gardens Cemetery, in the City or Town of Idaho Falls

County of Bonneville State of Idaho, who died on the 19th day of August, 1967, Aged ____ years ____ months

____ days, the cause of death being Pulmonary emphysema and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Dr. Waid attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private private or railway conveyance

to Fielding Memorial Cemetery in the City or Town of Idaho Falls County of Bonneville

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Bonneville it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 14th day of June, A.D. 19 74.

Permit issued to:
Wood Funeral Home
273 North Ridge
Idaho Falls, Idaho 83401

Janet M. Wick
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of ____ State of Idaho, this ____ day of ____, 19__.

Health Officer

FORM BH 56-019

TITLE 39, CHAPTER 2, VOL. 7 OF THE IDAHO CODE

"Sec. 39-211. No body shall be disinterred within the State of Idaho except upon a permit granted by the State Board of Health. The forms of disinterment permits shall be prepared by the State Board of Health. Disinterment and removal must be done under the personal supervision of a licensed embalmer, and must be done at an hour when there is the least possible exposure. Only such persons as are actually necessary shall be present. The coffin shall not be opened either at place of disinterment or place of destination, except special permit be issued by the State Board of Health. And in case of disinterment of bodies dead by reason of contagious and infectious diseases, as shown by the certificate of death given by the attending physician, the sexton and all other persons engaged in such removal or being present shall immediately thereafter change their clothing and properly disinfect their hands, head and face, provided, that such disinterment may also be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every permit: provided, also, that in case of any contagious and infectious disease where remains are to be shipped to points in other states, permission must first be obtained from the Secretary of State Board of Health of such State. The State Board of Health may also issue a special disinterment permit for legal purposes. This permit for legal purposes shall be granted only upon application of a prosecuting attorney or the Attorney General of this State, stating therein such facts which make it evident to the State Board of Health that the ends of justice require that disinterment be permitted. Such special disinterment for legal purposes shall be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every such special disinterment permit for legal purposes."

REC Certificate of Death

STATE OF IDAHO

State File No. 3446
Local Reg. No. 240
Reg. Dist. No. 610

BIRTH NO.

SEP 13 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 44 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 915 Canyon Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 915 Canyon Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) GLADYS
b. (Middle) (NMN)
c. (Last) SIMPSON

4. DATE OF DEATH (Month) August (Day) 19 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH November 2, 1898

9. AGE (In years last birthday) 68
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Denver, Colorado

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Orville James Allen
BIRTHPLACE Kansas

14. MOTHER'S MAIDEN NAME Alberta Brink
BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. 519-09-1490B

17. INFORMANT'S OWN SIGNATURE William M. Simpson
ADDRESS Idaho Falls, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 7954 Natural Causes — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) A Hiatus Hernia only

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. findings at autopsy

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-4, 1965, *to* Aug 14, 1967, *that I last saw the deceased alive on* Aug 14, 1967, *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Hoyt B. Woolley 641 (Degree or title) M. D.

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED 9/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE Aug. 23, 1967

24c. NAME OF CEMETERY OR CREMATORY Aultorest Crematory

24d. LOCATION (City, town, or county) Ogden (State) Utah

DATE REC'D BY LOCAL REG. Sept. 7-1967

REGISTRAR'S SIGNATURE Emma Burgess

25. EMBALMER Orland C. Buck

LICENSE NO. E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 9 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3447
Local Reg. No. 245
Reg. Dist. No. 610

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 107 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place) 8 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home-1086 Blaine Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville 108
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1086 Blaine Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LILLIE	VIOLA	PERRY	August 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	May 18, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Vernal, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Wesley Russell	Utah	Mary Marie Cook	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-42-8291	Wm R Russell	Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH less than 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 10 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	no operation	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Idaho Falls Bonn. Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb 27, 1967, *to* 8-20, 1967, *that I last saw the deceased alive on* 5-1, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. A. Sutton M.D.	1555 So. Blvd Idaho Falls Ida	8/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/22/67	Ammon Cemetery	Ammon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 26-1967	Anna Bridges	Jack A. Wood, Jr.	396

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Wood Funeral Home

SEP 1 1967

DUTIES:

1. *INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3448
Local Reg. No. 257
Reg. Dist. No. 610

BIRTH NO.

SEP 13 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Firth, Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) Ezra
c. (Last) Johnson

4. DATE OF DEATH (Month) Aug (Day) 22 (Year) 1967

5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 29 Nov 1885
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Labor 06
10b. KIND OF BUSINESS OR INDUSTRY Sexton
11. BIRTHPLACE (State or foreign country) Ovid, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John Johnson — BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Mary Ann Sorenson — BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 519-01-1093 A
17. INFORMANT'S OWN SIGNATURE Val A. Johnson — ADDRESS Idaho Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes mellitus

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1955, to Aug 22, 1967, that I last saw the deceased alive on Aug 22, 1967, and that death occurred at 800 p.m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 418
23b. ADDRESS Shelley Idaho
23c. DATE SIGNED 8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-25-67
24c. NAME OF CEMETERY OR CREMATORY Firth,
24d. LOCATION (City, town, or county) Firth, Bingham (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 5-1967
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Lloyd M Nalder
LICENSE NO. E 275

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Nalder's Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 24 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3449
Local Reg. No. 259
Reg. Dist. No. 610

BIRTH NO.

RECEIVED SEP 13 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 125
b. CITY OR TOWN Idaho Falls
(If outside corporate limits, write RURAL and give township)
LENGTH OF STAY (in this place) 25 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenview Chalet 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101 b. COUNTY Bonneville
c. CITY OR TOWN Idaho Falls
d. STREET ADDRESS (If rural, give location) 840 E. Elva Street

3. NAME OF DECEASED (Type or Print)
a. (First) MARTIN b. (Middle) EARL c. (Last) BEEBE

4. DATE OF DEATH (Month) (Day) (Year) August 23 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH November 18, 1894

9. AGE (In years last birthday) 72
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer, retired 04

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (State or foreign country) Ava, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Marcellus Clark Beebe
BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Martha Hatfield
BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 441-07-1693

17. INFORMANT'S OWN SIGNATURE O C Buck ADDRESS Joseph Beebe, via telephone Eastside, Orego

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 535X Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 1hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchopneumonia — 3 days
DUE TO (c) Chronic pulmonary fibrosis — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Idaho Falls, Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 57, *to* 8-23-, 19 67, *that I last saw the deceased alive on* Aug 7, 19 67, *and that death occurred at* 9:15P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M. D.

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 29, 1967

24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

24d. LOCATION (City, town, or county) Idaho Falls (State) Idaho

DATE REC'D BY LOCAL REG. Sept 7-1967

REGISTRAR'S SIGNATURE Emma Bridges

25. EMBALMER Orland C. Buck

LICENSE NO. E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 1 4 1993

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3450
Local Reg. No. 261
Reg. Dist. No. 610

BIRTH NO. 67-7561 RECEIVED SEP 13 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 18 1/2 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 575 Center Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Brent; b. (Middle) William; c. (Last) Edwards

4. DATE OF DEATH: (Month) August (Day) 24 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: August 24, 1967

9. AGE (In years last birthday): IF UNDER 1 YEAR — Months / Days; IF UNDER 24 HRS. — Hours 18 / Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jerry A. Edwards — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Carol Gustaveson — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: x Jerry A Edwards — ADDRESS: Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 7954 Premature gestation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. D. Davis MD (Degree or title) 134
23b. ADDRESS: Idaho Falls Ida
23c. DATE SIGNED: 9/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 8/25/67
24c. NAME OF CEMETERY OR CREMATORY: Tooele Cemetery
24d. LOCATION (City, town, or county) (State): Tooele Utah

DATE REC'D BY LOCAL REG.: Sept. 9-1967
REGISTRAR'S SIGNATURE: Anna Burgess
25. EMBALMER: Ralph M. Wood Ralph M Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3451
Local Reg. No. 262
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 344 Lomax

3. NAME OF DECEASED (Type or Print)
a. (First) Carl
b. (Middle) Ezra
c. (Last) Rhoades

4. DATE OF DEATH (Month) August (Day) 24 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH May 3, 1926
9. AGE (In years last birthday) 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ezra P. Rhoades — BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Rosella Johnson — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 20 4264
17. INFORMANT'S OWN SIGNATURE Rosella Rhoades — ADDRESS Idaho Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) septicemia — 10 days
DUE TO (c) pelvic abscess — 2 wks +

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION 8-7-67
19b. MAJOR FINDINGS OF OPERATION Gunshot wound of left colon, small bowel - left ilium, stomach
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Homicide 3
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Mint Bar Idaho Falls 22
21c. (CITY, TOWN, OR TOWNSHIP) Idaho Falls 13 **(COUNTY)** Bonneville 101 **(STATE)** Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? gunshot wound by customer in bar

22. *I hereby certify that I attended the deceased from* 8-12, 1967, *to* 8-23, 1967, *that I last saw the deceased alive on* Aug 23, 1967, *and that death occurred at* 3 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Warren A. Sutton, M.D. 515 (Degree or title)
23b. ADDRESS 1555 So Blvd Idaho Falls
23c. DATE SIGNED 8/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/28/67
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) Idaho Falls (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 9-1967
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Ralph M. Wood — LICENSE NO. 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63020

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 17 2006

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to —

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3452
Local Reg. No. 258
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): FRANKLIN
c. (Last): ORR, JR.

4. DATE OF DEATH (Month) (Day) (Year): Aug. 26, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: Feb. 28, 1938
9. AGE (In years last birthday): 29 — IF UNDER 1 YEAR: Months 5, Days 18 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Finance Dept. 19
10b. KIND OF BUSINESS OR INDUSTRY: Boise Cascade Corp.
11. BIRTHPLACE (State or foreign country): Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Franklin Orr. Sr. BIRTHPLACE: Pittsburn, Penn.
14. MOTHER'S MAIDEN NAME: Bertha Kalousek BIRTHPLACE: North Dakoata

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-42-2074
17. INFORMANT'S OWN SIGNATURE: X W. Franklin Orr ADDRESS: Dietrich, Idaho

18. CAUSE OF DEATH 8254
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): hemorrhagic shock ? — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): severe lacerations — few hours
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): ✓ 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 000 (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 26 67 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: auto accident

22. *I hereby certify that I attended the deceased from* ~ 5AM 8-26-67, 19__, *to* 6:41AM 8-26-67, 19__, *that I last saw the deceased alive on* 6:41 AM 8-26-67, 19__, *and that death occurred at* 6:41AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): George J. Barnard MD 027 1
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-26-1967
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 5-'67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood
LICENSE NO.: 413

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

SEP 1 4 1967

OCT 2 2 1985

DEC 1 2 1988

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 2453
Local Reg. No. 2453
Reg. Dist. No. 610

RECEIVED SEP 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place) 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101 b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 3217 East 17th Street

3. NAME OF DECEASED (Type or Print) a. (First) Joyce b. (Middle) c. (Last) Thompson

4. DATE OF DEATH (Month) August (Day) 27 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH November 9, 1894

9. AGE (In years last birthday) 72 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Texas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME R. V. LaForce BIRTHPLACE USA

14. MOTHER'S MAIDEN NAME Georgia Churchill BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 464 1293 81A

17. INFORMANT'S OWN SIGNATURE Charles A. Thompson ADDRESS Idaho Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular accident 331.X — INTERVAL BETWEEN ONSET AND DEATH 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Anemia Severe Type Undetermined

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 27, *19* 67, *to* August 27, *1967*, *that I last saw the deceased alive on* August 27, *1967*, *and that death occurred at* 9:20P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) W. Corbett, M.D.

23b. ADDRESS 798 South Blvd. Idaho Falls, Idaho

23c. DATE SIGNED Sept. 5, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 8/29/67

24c. NAME OF CEMETERY OR CREMATORY Utopia Cemetery

24d. LOCATION (City, town, or county) Utopia (State) Texas

DATE REC'D BY LOCAL REG. Sept. 9-1967

REGISTRAR'S SIGNATURE

25. EMBALMER Ralph M. Wood

LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 11 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3454
Local Reg. No. 263
Reg. Dist. No. 610

RECEIVED

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville — SEP 1 3 1967 — 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
Bureau of Vital Statistics
LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 415 5th Street

3. NAME OF DECEASED (Type or Print)
a. (First) Thone
b. (Middle) Lee
c. (Last) Roos

4. DATE OF DEATH (Month) (Day) (Year) August 28 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH February 1, 1901

9. AGE (In years last birthday) 66
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Businessman 19

10b. KIND OF BUSINESS OR INDUSTRY Roos Tackle Co.

11. BIRTHPLACE (State or foreign country) Milo, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Albert Roos
BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Edith A. Lee
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 09 1127

17. INFORMANT'S OWN SIGNATURE Margaret Roos
ADDRESS Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) D.O.A. on Arrival Hospital — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cause undetermined -
DUE TO (c) Coronary Occlusion suspect from Autopsy

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE D. Corbett (Degree or title) M.D.

23b. ADDRESS 798 South Blvd. Idaho Falls, Idaho

23c. DATE SIGNED Sept. 5, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/31/67

24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

24d. LOCATION (City, town, or county) Idaho Falls (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 9 '67

REGISTRAR'S SIGNATURE Anna Bridges

25. EMBALMER Ralph M. Wood Ralph M. Wood

LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3455
Local Reg. No. 36-67
Reg. Dist. No. 100

BIRTH NO.

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Keno Creek 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 110
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Kootenai Indian Mission

3. NAME OF DECEASED (Type or Print): a. (First) HELEN; b. (Middle) (none); c. (Last) Francis

4. DATE OF DEATH (Month) (Day) (Year): August 1, 1967

5. SEX: Female

6. COLOR OR RACE: Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1

8. DATE OF BIRTH: February 13, 1944

9. AGE (In years last birthday): 23 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 00

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Creston, British Columbia

12. CITIZEN OF WHAT COUNTRY?: Canada

13. FATHER'S NAME: Nicholas Francis — BIRTHPLACE: British Columbia

14. MOTHER'S MAIDEN NAME: Alice Adrian — BIRTHPLACE: British Columbia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE: Official Records — ADDRESS: OM

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hemorrhage — 〃
DUE TO (c) Gunshot wound Abdomen — 〃

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Generalized peritonitis
Perforated colon
Jejunum 10th Duodenum

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Homicide 3

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Keno Creek 18

21c. (CITY, TOWN, OR TOWNSHIP) 23 **(COUNTY)** 110 **(STATE)**: Bonners Ferry — Boundary — Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): August 1, 1967 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Shot with .22 caliber pistol

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, 19___, *that I last saw the deceased alive on* ____, 19___, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. M. Callahan Coroner 583 4

23b. ADDRESS: Bonners Ferry, Idaho

23c. DATE SIGNED: 8/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/6/67

24c. NAME OF CEMETERY OR CREMATORY: St. Peters Mission Cemetery

24d. LOCATION (City, town, or county) (State): Creston — British Columbia

DATE REC'D BY LOCAL REG.: Aug. 12, 1967

REGISTRAR'S SIGNATURE: Freya Stone

25. EMBALMER: Charles Malone

LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3456
Local Reg. No. 37-67
Reg. Dist. No. 100

RECEIVED SEP 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boundary 110 307
b. CITY OR TOWN Bonners Ferry
LENGTH OF STAY (in this place) ½ day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ball Creek 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 110 b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) 119 Van Buren

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) LaVERN c. (Last) FOUST
4. DATE OF DEATH (Month) (Day) (Year) August 15, 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH November 16, 1914
9. AGE (In years last birthday) 52 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woods Foreman 17
10b. KIND OF BUSINESS OR INDUSTRY Lumbering
11. BIRTHPLACE (State or foreign country) Glasgow, Montana
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Zinnie J. Foust BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Helen Detchmann BIRTHPLACE Minnesota
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 519-10-4155
17. INFORMANT'S OWN SIGNATURE John L. Foust Jr. ADDRESS Bonners Ferry, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH 1½ year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) atherosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Very recent burn of rt. arm + injury of rt eye

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Partial YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/6/66, 19___, to Aug 15, 1967, that I last saw the deceased alive on 6/26/67, 19___, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

23a. SIGNATURE John E. Hershey MD 790 (Degree or title)
23b. ADDRESS 5904 N. Division St. Spokane, WA
23c. DATE SIGNED 8/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/19/67
24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery
24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. 9/4/67
REGISTRAR'S SIGNATURE Loyla Stone
25. EMBALMER Charles O. Malone LICENSE NO. E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3457
Local Reg. No. 41-67
Reg. Dist. No. 100

RECEIVED
SEP 14 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 110 Boundary 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 110 b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) P. O. Box #495

3. NAME OF DECEASED (Type or Print)
a. (First) MYRTLE b. (Middle) LEAH c. (Last) WILSON

4. DATE OF DEATH (Month) (Day) (Year) August 22, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 27, 1890
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Homemaking
11. BIRTHPLACE (State or foreign country) Winnebago, Minnesota
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Charles W. VanAmber — BIRTHPLACE Wisconsin
14. MOTHER'S MAIDEN NAME Ellen Clark — BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-50-5359
17. INFORMANT'S OWN SIGNATURE Lucile W. Coffin — ADDRESS Rio de Janerio Brazil

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe general debility
Old CVA c hemiparesis — 4 yrs

19a. DATE OF OPERATION no
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) no
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/20, 1967, *to* 8/22, 1967, *that I last saw the deceased alive on* 8/22, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE A. Gosam 103 (Degree or title) MD 1
23b. ADDRESS Bonners Ferry, Ida
23c. DATE SIGNED 8/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/25/67
24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery
24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. 9/12/67
REGISTRAR'S SIGNATURE Gwyla Stone
25. EMBALMER [signature]
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Cahepl

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3458
Local Reg. No. 40-67
Reg. Dist. No. 100

BIRTH NO.

SEP 11 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: 110 Boundary 309

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry

c. LENGTH OF STAY (In this place): 9 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 110

b. COUNTY: Boundary

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry, Idaho

d. STREET ADDRESS (If rural, give location): Community Restorium

3. NAME OF DECEASED (Type or Print)

a. (First): Karen

b. (Middle): Marie

c. (Last): Kerr

4. DATE OF DEATH (Month) (Day) (Year): 8 - 25 - 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 1-31-1878

9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (State or foreign country): Ishpeming, Michigan

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Nels Thompson — BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 517-60-8274 T

17. INFORMANT'S OWN SIGNATURE: Ralph T. Kerr — ADDRESS: Columbia Falls, Mont.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9037

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Respiratory failure

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Fractured hip

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE XX (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Restorium

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Bonners Ferry Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Fell

22. *I hereby certify that I attended the deceased from* -- *, 19*61*, to* 8-25- *, 19*67*, that I last saw the deceased alive on* 8-25- *, 19*67*, and that death occurred at* 7:45 *Am., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 153 (Degree or title): MD

23b. ADDRESS: Bonners Ferry, Idaho

23c. DATE SIGNED: 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-29-67

24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery

24d. LOCATION (City, town, or county) (State): Bonners Ferry, Boundary, Idaho

DATE REC'D BY LOCAL REG.: 9-8-67

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature]

LICENSE NO.: E 453

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 216.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3459
Local Reg. No. 3
Reg. Dist. No. 670

BIRTH NO.

AUG 22 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 120 Butte
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Moore
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 2 miles N. on Hwy # 93A

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 27 Montana
b. COUNTY 555 Sanders
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Plains
d. STREET ADDRESS (If rural, give location) Box 387

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ELMER	H.	HENSLEY	August 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Jan. 9, 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman 10	Railroad	Kinta, Oklahoma	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard Hensley	Unobtainable	Unobtainable	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	456-01-2985	X Virgie B. Hensley	Plains, Mont.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Case not diagnosed-Probable Cororary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Attended as Coroner Only, Did not see alive *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 4:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE	583 (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. H. Marvel	Butte Co. Coroner 4	Arco, Idaho	8-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) 3	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	8-17-67	Plains, Montana	Plains, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 21-1967	Betty J. Marvel	C. H. Marvel	E-457

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Marvel Memorial Chapel, Arco

AUG 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 3 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3460
Local Reg. No. 4
Reg. Dist. No. 670

BIRTH NO.

RECEIVED SEP 8 1967 Bureau of Vital Statistics

404

1. PLACE OF DEATH
a. COUNTY 120 Butte
b. CITY OR TOWN Arco
c. LENGTH OF STAY (in this place) 3½ hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 120 Butte
c. CITY OR TOWN Rural-Moore
d. STREET ADDRESS (If rural, give location) 1 mile N. of Moore

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	MITCHELL	BURCH, SR.	August 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 22, 1904	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Oaktown, Indiana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John W. Burch	Winfield, Kansas	Henretta Willis	Oaktown, Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-09-7227	Mrs. John M. Burch	Moore, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion	3 Hrs.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Coronary Artery Disease	3 yrs.
DUE TO (c)	Arteriosclerosis	10 yrs
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Gastric Ulcer, Bleeding	5

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 1967 *to* Aug 30 1967, *that I last saw the deceased alive on* Aug 30, 1967, *and that death occurred at* 4:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R V Sanders MD	031	Arco, Ida	9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-2-67	Lost River	Moore, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 7-1967	Betty J. Marvel	C. H. Marvel	E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUN 24 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3461
Local Reg. No.
Reg. Dist. No.

RECEIVED AUG 17 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 130 Camas
b. CITY OR TOWN Fairfield
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rural-About 7-Miles S.E.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 130 Camas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fairfield
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Harold
b. (Middle) Dixon
c. (Last) Lee

4. DATE OF DEATH (Month) (Day) (Year) August 9, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Dec. 9, 1908

9. AGE (In years last birthday) 58
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 07

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Fir Grove, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hyrum D. Lee
BIRTHPLACE Tooele, Utah

14. MOTHER'S MAIDEN NAME Alice E. Dixon
BIRTHPLACE Clifton, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 516-22-7132

17. INFORMANT'S OWN SIGNATURE Harold D. Lee
ADDRESS Fairfield,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 22 Cal Gun shot to Head — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Self Inflicted
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide 2

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.) 00

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 130 **(STATE)** 5 mi. So E. of Fairfield Camas Co Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not See Alive, 19—, *to* —, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE Marion J. Kerns, M.D. 583 (Degree or title) Coroner

23b. ADDRESS Fairfield Ida

23c. DATE SIGNED 14 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 12, 1967

24c. NAME OF CEMETERY OR CREMATORY Manard Cemetery

24d. LOCATION (City, town, or county) (State) Fairfield Camas- Idaho

DATE REC'D BY LOCAL REG. 15 Aug. 1967

REGISTRAR'S SIGNATURE Estelle Waight

25. EMBALMER Raleen S. Meyer

LICENSE NO. E-424

FIRM NAME Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 24 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3462
Local Reg. No. 13
Reg. Dist. No. 360

BIRTH NO.

AUG 10 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 1707-4th. Street North

3. NAME OF DECEASED (Type or Print)
a. (First) Melda
b. (Middle) Maxine
c. (Last) Sneed

4. DATE OF DEATH (Month) (Day) (Year) August 1, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorded 4
8. DATE OF BIRTH Aug. 3, 1928
9. AGE (In years last birthday) 38 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Nampa, Iddho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME F.L. Youree — BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Loretta Richardson — BIRTHPLACE Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-26-9732
17. INFORMANT'S OWN SIGNATURE F. L. Youree — ADDRESS Nampa

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1907

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Metastasis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Malignant melanoma

DUE TO (c) Thigh

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-2, 1963, *to* 8/1, 1967, *that I last saw the deceased alive on* 7/30, 1967, *and that death occurred at* 8:05A. *m., from the causes and on the date stated above.*

23a. SIGNATURE S. C. Tapp, MD 524 (Degree or title)
23b. ADDRESS 1619 Canyon
23c. DATE SIGNED 8/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY Hillrest Cemetery
24d. LOCATION (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 8, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Mesenbrink
LICENSE NO. E-487

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME Nisip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 21 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3463
Local Reg. No. 31
Reg. Dist. No. 360

RECEIVED AUG 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142 b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 223 Amity Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
SHIZU		YAMADA	8	1	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	Japanese 5	Married 3	11/7/1885	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewief 01	Home	Japan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unkown		unknown Family Records By:	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no	no	[signature]	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute myocardial infarct	1 day
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Aspiration Pneumonia	2 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1963, *to* Aug. 1, 1967, *that I last saw the deceased alive on* Aug. 1, 1967, *and that death occurred at* 6:25 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Walter Webber M.D.	Nampa, Idaho	8-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/3/1967	Hillcrest Memorial Gardens	Canyon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 17, 1967	Mrs. Martin Walmsley	[signature]	E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3464
Local Reg. No. 14
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN Nampa
c. LENGTH OF STAY (If outside corporate limits, write RURAL and give distance)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Manor 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 140 COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa -Rural
d. STREET ADDRESS (If rural, give location) Route # 4

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) F. c. (Last) ALLEN

4. DATE OF DEATH (Month) (Day) (Year) August 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	April 14, 1875	92				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Franklin Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Allen	England	Ellen Thomas	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518 54 0398A	Orville Allen	Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4937

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senile Degeneration — 4 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Tumor left breast — 1 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 8-11- , 1966, *to* 8-2- , 1967, *that I last saw the deceased alive on* 8-2 , 1967, *and that death occurred at* 6:45P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald E Wesche 559	MD	Nampa Idaho	8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 7, 1967	Kohlerlawn Cemetery	Nampa Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 8, 1967	Mrs Martin Walmsley	FIRM NAME Alsip Funeral Chapel	E-496

Federal Security Agency
United States Public Health Service
Form DH-63021

Local Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3485
Local Reg. No. 11
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 140 Canyon 204
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Parma
c. LIMITS OR STAY (in this place): 4mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Meyers Ranch Home 179

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 38 Oregon
b. COUNTY: 555 Malheur
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nyssa
d. STREET ADDRESS (If rural, give location): 407 King Ave

3. NAME OF DECEASED (Type or Print)
a. (First): Harriet
b. (Middle): 0
c. (Last): Pennie

4. DATE OF DEATH (Month) (Day) (Year): 8-3-1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 12-12-1888
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Allison L Carter — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Florence Boyer — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 540-32-6136
17. INFORMANT'S OWN SIGNATURE: x Mrs. Robert R. Wilson — ADDRESS: Nyssa Oregon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Thrombosis right middle meningeal artery — 6 mo
DUE TO (c) Hypertension — years

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Reduplication Lt ureters — 78

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-22, 1967, *to* 8-13, 1967, *that I last saw the deceased alive on* 4-17, 1967, *and that death occurred at* 1130p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David W Sarazin 664 MD
23b. ADDRESS: 213 Main Nyssa Oreg
23c. DATE SIGNED: 8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 8-7-1967
24c. NAME OF CEMETERY OR CREMATORY: Baker
24d. LOCATION (City, town, or county) (State): Baker Oregon

DATE REC'D BY LOCAL REG.: Aug. 8, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. FUNERAL DIRECTOR: B. L. Lunkaemper — ADDRESS: Nyssa Oregon

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

STATE OF IDAHO

State File No. 3466
Local Reg. No. 19
Reg. Dist. No. 360

RECEIVED
AUG 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Caldwell, Idaho
LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 141 IDAHO b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) 107 Palo Alto

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	WILMA	GRACE	SMITH		8	3	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married 3	March 29, 1919	48	4	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Lady 25	Irenes Fashions	Caldwell, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Vogt	Albion, Nebraska	Alma G. Smith	Greeley, Colo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	519-10-3168	x Lee Smith	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) multiply inter-crainal metastases
DUE TO (c) metastases of breast cancer

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ----

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
March 1967	Mx inter-crainal metastases	YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
no		Caldwell, Canyon, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
-------- m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Oct, 1945, *to* Aug. 3, 19 67, *that I last saw the deceased alive on* Aug 3, 19 67, *and that death occurred at* 2:30pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
473 MD	305 East Logan, Caldwell, Ida	Aug 11, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/7/67	Canyon Hill	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 11, 1967	Mrs Martin Walmsley	Leonard C. Flahiff	F-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3467
Local Reg. No. 26
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 16 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blvd. Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 703-7 Avenue South

3. NAME OF DECEASED (Type or Print) a. (First) GRACE b. (Middle) c. (Last) LAY

4. DATE OF DEATH (Month) (Day) (Year) August 3, 1967

5. SEX F

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Aug. 10, 1878

9. AGE (In years last birthday) 88
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Cotton BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME no record BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 60 3932

17. INFORMANT'S OWN SIGNATURE ADDRESS Family Records, By: Edna Weibel

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-20, 1967, *to* 8-3, 1967, *that I last saw the deceased alive on* 7-19, 1967, *and that death occurred at* 4:30A. m., *from the causes and on the date stated above.*

23a. SIGNATURE Henry C. Wesche M.D 560 (Degree or title)

23b. ADDRESS Nampa Idaho

23c. DATE SIGNED 8-9-67.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 8, 1967

24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery

24d. LOCATION (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 16, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Larry J. Kranck LICENSE NO. E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 3468
Local Reg. No. 15
Reg. Dist. No. 360

BIRTH NO. RECEIVED STATE OF IDAHO

AUG 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1311 Willow St.

3. NAME OF DECEASED (Type or Print)
a. (First) Aubrey b. (Middle) B. c. (Last) Cooper

4. DATE OF DEATH (Month) (Day) (Year) Aug. 4, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 17, 1886
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Tecumseh, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Unknown — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-0498
17. INFORMANT'S OWN SIGNATURE Mrs. Aubrey B. Cooper — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5400

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock — INTERVAL BETWEEN ONSET AND DEATH: 12 HR

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) gastro-duodenal bleeding — 24 HR
DUE TO (c) ulcer — 5 YR

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION 28 Jul 67
19b. MAJOR FINDINGS OF OPERATION phlegmon incl. ac. cholecystitis + Duod. ulcer
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 27 Jul, 1967, *to* Aug 4, 1967, *that I last saw the deceased alive on* 4 Aug, 1967, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Jr Montgo 367 (Degree or title) MD
23b. ADDRESS 222. E. Logan
23c. DATE SIGNED 8 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Aug. 14, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Kenneth E. Spence
LICENSE NO. E-395

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3469
Local Reg. No. 23
Reg. Dist. No. 360

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141 AUG 15 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics) Caldwell
c. LENGTH OF (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benjamin's Nursing Home 291

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1120 Albany

3. NAME OF DECEASED (Type or Print)
a. (First) Lyle b. (Middle) c. (Last) Olson

4. DATE OF DEATH (Month) (Day) (Year) August 5, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 18, 1885
9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hudson, South Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Avle Olson BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-54-4660
17. INFORMANT'S OWN SIGNATURE Mrs Lyle Olson ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gt. cerebral artery thrombosis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-4, 1967, *to* 8-5, 1967, *that I last saw the deceased alive on* 8-5, 1967, *and that death occurred at* 8:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 166 (Degree or title)
23b. ADDRESS Caldwell Ida
23c. DATE SIGNED 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 14, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Kenneth E. Spence
LICENSE NO. E-395

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3470
Local Reg. No. 28
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 14/ Canyon 000
b. CITY OR TOWN Caldwell
c. LENGTH OF STAY (If outside corporate limits)
d. FULL NAME OF HOSPITAL OR INSTITUTION Caldwell Memorial Hosp. 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wilder
d. STREET ADDRESS (If rural, give location) Box 273

3. NAME OF DECEASED (Type or Print): a. (First) Julia b. (Middle) E. c. (Last) Rogers

4. DATE OF DEATH (Month) (Day) (Year): August 5, 1967

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: October 19, 1890
9. AGE (In years last birthday): 77 | IF UNDER 1 YEAR Months: 3 | Days: 16 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Farmington, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Pleas Williams — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Ann Wood — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-10-6272
17. INFORMANT'S OWN SIGNATURE: x Charles Rogers Jr. ADDRESS

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

334X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1967, *to* Aug 5, 1967, *that I last saw the deceased alive on* Aug 5, 1967, *and that death occurred at* 7:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Caldwell Ida
23c. DATE SIGNED 8-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-8-67
24c. NAME OF CEMETERY OR CREMATORY: Wilder Cemetery
24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: Aug. 17, 1967
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: Forrest C. Flaniff
LICENSE NO.: E 481
FIRM NAME: Homedale's Flaniff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 8 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3471
Local Reg. No. 21
Reg. Dist. No. 360

Certificate of Death

RECEIVED
AUG 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): 124 Galveston

3. NAME OF DECEASED (Type or Print)
a. (First): HENRY
b. (Middle): GROVER
c. (Last): HUFFMAN

4. DATE OF DEATH (Month) 8 (Day) 7 (Year) 67

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 29, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months 1, Days 8 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian 01
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): Kimeo, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Daniel P Huffman Danville, Ill.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Mary Cushing Ludlow. Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 512-10-9161A
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Blanche A. Huffman

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis Generalized — 30 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 Aug, 1967, *to* 7 Aug, 1967, *that I last saw the deceased alive on* 7 Aug, 1967, *and that death occurred at* 5:10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A L Soulsen MD. 651
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 10 Aug 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/10/67
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Aug 11, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

P- Certificate of Death

STATE OF IDAHO

State File No. 3472
Local Reg. No. 20
Reg. Dist. No. 360

BIRTH NO.

AUG 14 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) Route # 3

3. NAME OF DECEASED (Type or Print)
a. (First) FRANCES
b. (Middle) MAY 051
c. (Last) WIEGAND

4. DATE OF DEATH (Month) 8 (Day) 7 (Year) 67

5. SEX F

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Dec. 2, 1910

9. AGE (In years last birthday) 56
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Broadripple, Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Roy Engle
BIRTHPLACE Indiana

14. MOTHER'S MAIDEN NAME Esther Lummis
BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

583X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatitis — INTERVAL BETWEEN ONSET AND DEATH 6-26-67

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 6-26-67

19b. MAJOR FINDINGS OF OPERATION Hepatitis + Gall bladder & stones

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-23-67, 19___, *to* 8-7-67, 19___, *that I last saw the deceased alive on* 8-6-67, 19___, *and that death occurred at* 1:39 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 389 (Degree or title) MD
John R. Nielsen

23b. ADDRESS 303 E. Logan Caldwell, Idaho

23c. DATE SIGNED 8-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/10/67

24c. NAME OF CEMETERY OR CREMATORY Hillcrest

24d. LOCATION (City, town, or county) (State) Near Nampa, Idaho

DATE REC'D BY LOCAL REG. Aug 11 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Leonard C. Flahiff

LICENSE NO. E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 3 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3473
Local Reg. No. 44
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home- 309 Holly St. Nampa 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 309 Holly Street

3. NAME OF DECEASED (Type or Print)
a. (First) JASPER
b. (Middle) JACOB
c. (Last) ADER

4. DATE OF DEATH (Month) (Day) (Year) August 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH October 22, 1912
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Midvale Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John W. Ader — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Bertha Pickett — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 42 2174
17. INFORMANT'S OWN SIGNATURE Family Records - By: Jerry J. Kowalski — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apparent Heart Attack

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home
21c. (CITY, TOWN, OR TOWNSHIP) Nampa (COUNTY) Canyon (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 7 67 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE John W. Gunn 588 (Degree or title) J. P. S
23b. ADDRESS Ct. House Caldwell, Ida
23c. DATE SIGNED Aug 22 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 24, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Mesenbrink
LICENSE NO. E-487

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 19 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3474
Local Reg. No. 30
Reg. Dist. No. 360

BIRTH NO. RECEIVED STATE OF IDAHO

AUG 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Memorial Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Wilder Labor Camp

3. NAME OF DECEASED (Type or Print)
a. (First): Ricardo
b. (Middle):
c. (Last): Castillo

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1967

5. SEX: Male
6. COLOR OR RACE: Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: Feb. 7, 1946
9. AGE (In years last birthday): 21 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Far, Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): San Jaun, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Esmerejildo Castillo — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 461-76-3065
17. INFORMANT'S OWN SIGNATURE: X Rita Quintero — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gunshot wound chest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Homicide 3
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Probably farm. 02
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Wilder. 13 Canyon. 140 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 9 1967 6.P m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?: Shot in left shoulder & chest - How still undetermined

22. *I hereby certify that I attended the deceased from* Inspection Only 2, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wesche MR. 583 Corona 4
23b. ADDRESS: Nampa - Idaho
23c. DATE SIGNED: 8-14-67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Aug. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Aug. 17, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D. Davis
LICENSE NO.: E 399

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3475
Local Reg. No. 34
Reg. Dist. No. 360

RECEIVED AUG 15 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1706 Idaho St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Roger	W.	Batt	August 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 3, 1889	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Batt — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Emma Wilkins — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-34-5368
17. INFORMANT'S OWN SIGNATURE X Mrs Roger Batt — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic cardiovascular disease — 10 years
DUE TO (c) ---

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. carcinoma of prostate

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
---	---	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
no	---	Caldwell, Canyon, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
----- m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	------

22. *I hereby certify that I attended the deceased from* Oct, 1945, *to* Aug. 9, 1967, *that I last saw the deceased alive on* Aug 9, 1967, *and that death occurred at* 6:30 Am., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	423 M.D.	305 East Logan, Caldwell	Aug. 10, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 12, 1967	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 14, 1967	Mrs. Martina Walmsley	Merville D. Davis	E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK Ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 18 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3476
Local Reg. No. 27
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 143 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 140 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa Rural
d. STREET ADDRESS (If rural, give location) Rural Rte. #6

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	George	Edgar	Pirnie	Aug. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Dec. 14, 1897	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farming	Weissert, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alex Pirnie	Scotland	Lusina Powell	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		506-46-6571	X Dorothy Pirnie	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1808

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Cancer from L. Kidney — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) to Lungs + Rib Cage

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept, 1964 *to* 9 Aug, 1967, *that I last saw the deceased alive on* 9 Aug, 1967, *and that death occurred at* 10:20 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
328 (Degree or title) R Brangum MD	Nampa, Idaho	8/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 11, 1967	Kohlerlawn Cemetery	Nampa Canyon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 16, 1967	Mrs. Martina Walmsley	Richard W. Messenbrink	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3477
Local Reg. No. 25
Reg. Dist. No. 360

RECEIVED
AUG 15 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 140 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Rural Rt.
c. LENGTH OF STAY (If not a resident)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home, Rt. # 3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) Rt. # 3

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	William	Archie	Fugate	Aug. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Feb. 8, 1897	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired School Teacher	12	Colby, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
W. C. Fugate	Tenn.	Pearl Summers	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	War I 3	519-42-0251	X Mrs. Archie Fugate	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: about 10 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes Mellitus — 5 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1962 *to* Aug 9, 1967, *that I last saw the deceased alive on* Aug 8, 1967, *and that death occurred at* 22 m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[illegible] 36 (Degree or title)	Caldwell Idaho	8/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 11, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 14 1967	Mrs. Martina Walmsley	Merville D Davis	E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

AUG 29 1967

OCT 1 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3478
Local Reg. No. 29
Reg. Dist. No. 360

BIRTH NO.

AUG 18 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: 147 Canyon 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 147

b. COUNTY: Canyon

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho

d. STREET ADDRESS (If rural, give location): Route # 6

3. NAME OF DECEASED (Type or Print)

a. (First): MARIA

b. (Middle): MADRID 051

c. (Last): SUBIA

4. DATE OF DEATH (Month) 8 (Day) 12 (Year) 67

5. SEX: F

6. COLOR OR RACE: Mexican

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 17, 1903

9. AGE (In years last birthday): 64

If under 1 year: Months 3 Days 25

If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Chihuha, Mexico

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME / BIRTHPLACE: Matividad Madrid Chihuha, Mexico

14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Lucas Gonzales Chihuha, Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-42-4827

17. INFORMANT'S OWN SIGNATURE / ADDRESS: x Robert Page 1444 Gladwick 90220 Compton, Cal

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2021

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 HR.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): ascites - carcinomatosis — 3 wk.

DUE TO (c): Lymphoblastoma Lt. Tonsil — 3 mo.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: 15 MAY 67

19b. MAJOR FINDINGS OF OPERATION: Lymphoblastoma Tonsil Lt.

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 May, 1967, *to* 12 aug, 1967, *that I last saw the deceased alive on* 11 aug, 1967, *and that death occurred at* 7:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J.L. Montgomery M.D. 367

23b. ADDRESS: 222 E. Logan

23c. DATE SIGNED: 14 aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Mauso Ent. 4

24b. DATE: 8/14/67

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest

24d. LOCATION (City, town, or county) (State): Near Nampa, Idaho

DATE REC'D BY LOCAL REG.: Aug. 17, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Lucy M. Flahiff

LICENSE NO.: E 393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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State File No. 3479
Local Reg. No. 32
Reg. Dist. No. 360

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 1½ MONTHS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 142
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 516 3rd ST. SO.

3. NAME OF DECEASED (Type or Print)
a. (First): LAURA
b. (Middle): P.
c. (Last): CLEMENT

4. DATE OF DEATH (Month) (Day) (Year): AUG. 12, 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: NOV. 4, 1904
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE 01
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): SWAN LAKE, IDAHO
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: NIEL PETTERSON — BIRTHPLACE: NO RECORD
14. MOTHER'S MAIDEN NAME: EVA QUIGLEY — BIRTHPLACE: UTAH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-38-5115
17. INFORMANT'S OWN SIGNATURE: Laura L. Clement — ADDRESS: NAMPA

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cat cell Carcinoma J Bley — INTERVAL BETWEEN ONSET AND DEATH: 2 Mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-10-67, 19__, *to* 8-12-, 1967, *that I last saw the deceased alive on* 8-12-, 19 67, *and that death occurred at* 5:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard C. Tinyer, M.D. 666 1
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL 1
24b. DATE: 8-15-67
24c. NAME OF CEMETERY OR CREMATORY: MT. CALVARY CEMETERY
24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Aug. 18, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: N. B. Shepherd
LICENSE NO.: 473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3480
Local Reg. No. 37
Reg. Dist. No. 360

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 23 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 140 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa-Rural
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home- Route # 4 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa-Rural
d. STREET ADDRESS (If rural, give location) R# 4

3. NAME OF DECEASED (Type or Print)
a. (First) KIKUEMON
b. (Middle)
c. (Last) NAKAMURA

4. DATE OF DEATH (Month) (Day) (Year) August 12, 1967

5. SEX Male
6. COLOR OR RACE Japanese 5
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 7, 1883
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Okayama Japan
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Hyzo Nakamura — BIRTHPLACE Japan
14. MOTHER'S MAIDEN NAME Kiyo Watanabe — BIRTHPLACE Japan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 40 0870 A
17. INFORMANT'S OWN SIGNATURE Masa Nakamura — ADDRESS Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the colon

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 3/16/67
19b. MAJOR FINDINGS OF OPERATION Carcinoma of the colon
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 29, 1967, *to* June 29, 1967, *that I last saw the deceased alive on* June 29, 1967, *and that death occurred at* 8:45 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 766 (Degree or title) [signature]
23b. ADDRESS 824-17th Ave So, Nampa
23c. DATE SIGNED 8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 17, 1967
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) Nampa (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 22, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Larry J. Krouse — LICENSE NO. E-447

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3481
Local Reg. No. 76
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 19 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1603 Rochester

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	L.	Lowe	August 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Feb. 14, 1881	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04		Union County, Georgia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew Lowe	Georgia	Nancy Dean	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-60-2143	Jessie Lowe	Parma Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4468

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Nephrosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-7-63, 19____, *to* 8-13-67, 19____, *that I last saw the deceased alive on* 8-13-67, 19____, *and that death occurred at* 6:30A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lyle Stones, M.D. 505	222 East Elm—Caldwell, Idaho	8-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Aug. 15, 1967	Pleasant Mound Cemetery	Dora, Missouri

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 18, 1967	Mrs. Martina Walmsley	Merville D. Davis	E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 21 1967 Bureau of Vital Statistics

State File No. 3482
Local Reg. No. 33
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carter Nursing Home 053

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 018
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kuna
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): L.
c. (Last): Book

4. DATE OF DEATH (Month) (Day) (Year): Aug. 13, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 14, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Harrison, Arkinsas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James L. Book — BIRTHPLACE: Unk
14. MOTHER'S MAIDEN NAME: Isabel Walker — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-42-4672A
17. INFORMANT'S OWN SIGNATURE: George M. Reynolds — ADDRESS: Meridian

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1966 *to* Aug 13, 1967, *that I last saw the deceased alive on* 13 Aug, 1967, *and that death occurred at* 6:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Joseph B. Marquez 326 (Degree or title): MD
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 8/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-16-67
24c. NAME OF CEMETERY OR CREMATORY: Kuna Cemetery
24d. LOCATION (City, town, or county) (State): Kuna, Idaho

DATE REC'D BY LOCAL REG.: Aug. 18, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature]
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robison Chapel of the Chimes

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3483
Local Reg. No. 42
Reg. Dist. No. 360

BIRTH NO.

AUG 24 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 140 CANYON 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL NAMPA
c. LENGTH OF STAY (If outside place) 2 YRS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ROUTE 2 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 140
b. COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL NAMPA
d. STREET ADDRESS (If rural, give location) ROUTE 2

3. NAME OF DECEASED (Type or Print)
a. (First) LUCY
b. (Middle) MAY
c. (Last) WENTWORTH

4. DATE OF DEATH (Month) (Day) (Year) AUGUST 14, 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2
8. DATE OF BIRTH: MAY 18, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME MAKER 01
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): STORMLAKE, IOWA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM YATES — BIRTHPLACE: NO RECORD
14. MOTHER'S MAIDEN NAME: EMMA MILLS — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-38-4089
17. INFORMANT'S OWN SIGNATURE: X Coleman D. Gernet — ADDRESS: SOUTH LANCASTER, MASS.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3318

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-8-, 1966, *to* 8-14-, 1967, *that I last saw the deceased alive on* _____ 19__, *and that death occurred at* 7:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 454 (Degree or title) MD. 1
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 8-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 73
24b. DATE: 8-17-67
24c. NAME OF CEMETERY OR CREMATORY: MT. HOPE CEMETERY
24d. LOCATION (City, town, or county) (State): COLLEGE PLACE, WASHINGTON

DATE REC'D BY LOCAL REG.: Aug. 23, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd — LICENSE NO. 473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 12 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3484
Local Reg. No. 40
Reg. Dist. No. 360

RECEIVED
AUG 24 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL) Nampa
c. LENGTH OF STAY (If this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) R# 3

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Elbert	C.	Zimmerman	August	15,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	November 9, 1879	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04		Pennsylvania	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Zimmerman	No record	No record	No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			J. C. Zimmerman	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pulmonary Embolus	10mn
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease	10yr
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Congestive Heart Failure	6mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
			m.		

22. *I hereby certify that I attended the deceased from* Aug 1, 1967, *to* Aug 15, 1967, *that I last saw the deceased alive on* Aug 15, 1967, *and that death occurred at* 2:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
326	Nampa, Idaho	Aug. 21, '67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 18, 1967	Kohlerlawn Cemetery	Nampa Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 23, 1967	Mrs. Martina Walmsley	Roy W. Vinciguerra	E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 9 1978

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 14 1996

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 24 1967
Bureau of Vital Statistics

State File No. 3485
Local Reg. No. 41
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa-Rural
d. STREET ADDRESS (If rural, give location): R# 5

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) MAURICE c. (Last) DOUGHTY

4. DATE OF DEATH: (Month) August (Day) 15, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 24, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Ranch Foreman 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Marysville, Texas
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Charles Doughty — BIRTHPLACE: Alabama
14. MOTHER'S MAIDEN NAME: Mattie McCarty — BIRTHPLACE: Tennessee
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 446-05-2937
17. INFORMANT'S OWN SIGNATURE: x Maggie Doughty — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Bronchial Asthma — Lifelong

DUE TO (c) Pulmonary Emphysema — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 19 67 *to* Aug, 19 67, *that I last saw the deceased alive on* Aug 14, 19 67 *and that death occurred at* 6:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] 115 (Degree or title)
23b. ADDRESS: Nampa Ida
23c. DATE SIGNED: 8-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE REC'D BY LOCAL REG.: Aug. 23, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [illegible] LICENSE NO. E-496
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 5 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3486
Local Reg. No. 38
Reg. Dist. No. 360

RECEIVED
AUG 23 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 140 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma, Idaho
c. LENGTH OF STAY (in this place): School
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1 Mile West of Apple Valley 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 370
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale, Idaho
d. STREET ADDRESS (If rural, give location): Homedale

3. NAME OF DECEASED (Type or Print)
a. (First): LILLIAN
b. (Middle): FLORENCE
c. (Last): HARMON

4. DATE OF DEATH (Month) 8 (Day) 16 (Year) 67

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 23, 1903
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months 1, Days 23 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Wetaskiwin, Alberta Canada
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: x Barbara Johnson — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9295

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning - accidental

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway - Drain ditch 18
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 140 Canyon (STATE) Idaho.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Fell into drain ditch & drowned.

22. *I hereby certify that I attended the deceased from* Inspection only, *19*__, *to* ____, *19*__, *that I last saw the deceased alive on* ____, *19*__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

Found dead in ditch about 7:30 am

23a. SIGNATURE: Henry C Wesch MD. 583 Corona 4 (Degree or title)
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 8/18/67
24c. NAME OF CEMETERY OR CREMATORY: Homedale-Marsing
24d. LOCATION (City, town, or county) (State): Near Marsing, Idaho

DATE REC'D BY LOCAL REG.: Aug. 22, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Lucy M. Flahiff
LICENSE NO.: E393
FIRM NAME: HomedaleSs Flahiff Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

STATE OF IDAHO

State File No. 3487
Local Reg. No. 36
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
AUG 23 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 141 Canyon 105
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
c. LENGTH OF STAY (in this place) 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) 1916 Maple

3. NAME OF DECEASED (Type or Print)
a. (First) DORTHY
b. (Middle) OPAL
c. (Last) WILDER

4. DATE OF DEATH (Month) 8 (Day) 16 (Year) 67

5. SEX F

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 25, 1906

9. AGE (In years last birthday) 61
IF UNDER 1 YEAR Months 4 Days 21
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Blair, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjiman Peck
BIRTHPLACE Blair, Nebraska

14. MOTHER'S MAIDEN NAME Louisa Compton
BIRTHPLACE Blair, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 519-40-0793

17. INFORMANT'S SIGNATURE x Mrs L Wilder
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adeno Carcinoma primary in 1750
INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 Year.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) left ovary with generalyd
DUE TO (c) Abdominal metastasis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Bilateral oophorectomy & hysterectomy 1 1/4 yrs ago showing new findings

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 55, *to* 8-16, 19 67, *that I last saw the deceased alive on* 8-16, 19 67, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Clark E Kinnick 289
(Degree or title) MD
23b. ADDRESS 1819 Ellis St Caldwell Idaho
23c. DATE SIGNED 8-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/21/67
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 21, 1967
REGISTRAR'S SIGNATURE Mrs Martina Walmsley

25. EMBALMER Guy M. Flahiff
LICENSE NO. E 293
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

MAY 25 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-8773

BIRTH NO.

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 23 1967 VSU

State File No. 3488
Local Reg. No. 35
Reg. Dist. No. 360

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN Caldwell, Idaho
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 141 Canyon
c. CITY OR TOWN Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) Hospital

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
CLAY	DANIEL	BAUER Jr.	8	16	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Infant	8/16/67				4	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant 02	infant	Caldwell, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clay D. Bauer Sr.	Bismark No. Dak.	Carol Very	Nampa, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	None	x Clay D Bauer	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematur Infant — INTERVAL BETWEEN ONSET AND DEATH 4hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Premature separation of
DUE TO (c) the placenta.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-16, 1967, *to* 8-16, 1967, *that I last saw the deceased alive on* 8-16, 1967, *and that death occurred at* 4A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
258	Robert H. Jensen, M.D. 222 EAST LOGAN	8-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/18/67	Canyon Hill	CALDWELL, IDAHO Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 21, 1967	Mrs Martina Walmsley	Lucy M. Flahiff	E 393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3489
Local Reg. No. 34
Reg. Dist. No. 360

RECEIVED
AUG 23 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Glen Haven Trailer Court 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 360 Caldwell Blvd.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Maurice	E.	Teasley	August 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	January 9, 1913	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. 10	P.F.E.	Codell Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James F. Teasley	Kansas	Minnie E. Drake	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W.II 4		X Lela Teasley	Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suicide by hanging — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Mental Depression
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide 2	Home 01	Nampa 13 Canyon 142 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
~~8/16~~ m.		

22. *I hereby certify that I attended the deceased from* Inspection only, *19____, to* Found dead at 7:15 am. *19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Wesche M.D. Coroner	583 24	Nampa Idaho	8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Aug. 19, 1967	Plainville Cemetery	Plainville, Kansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 21, 1967	Mrs. Martina Walmsley	Richard W. Messbrand	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 5 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. SEP 6 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

COPY

Certificate of Death

STATE OF IDAHO

State File No. 3490
Local Reg. No. 39
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 24 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home - 615 19 Ave. So. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 615-19 Avenue South

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LETTIE	MAY	BAKER	August 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	April 19, 1895	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaking 0		Clay County Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Washington Johns	Kansas	Mary Josephine Allen	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 36 0593	x Albert F. Johns	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4201 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetis - Gallbladder Disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* found, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 11:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C. Worche MD 583	Coroner 4	Nampa Idaho	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 21, 1967	Kohlerlawn Cemetery	Nampa Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 23, 1967	Mrs. Martina Walmsley	[signature]	E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3491
Local Reg. No. 47
Reg. Dist. No. 360

BIRTH NO.

RECEIVED STATE OF IDAHO

AUG 30 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 14
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1211 Dearborn St.

3. NAME OF DECEASED (Type or Print)
a. (First): Adella
b. (Middle): M.
c. (Last): O'Hara

4. DATE OF DEATH: (Month) (Day) (Year): August 18, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: April 11, 1878

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months / Days
IF UNDER 1 DAY: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael P. Conway
BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Francis Surge
BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Herbert Q. Hultz
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Thrombosis
INTERVAL BETWEEN ONSET AND DEATH: 4 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cardiac Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic Heart Disease

332X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Aug 18, 1967, *that I last saw the deceased alive on* Aug 17, 1967, *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23a. SIGNATURE AND DEGREE OR TITLE: Robert H. Jensen M.D. 258
23b. ADDRESS: 222 EAST LOGAN CALDWELL IDAHO
23c. DATE SIGNED: 8/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY (City, town, or county) (State): Canyon Hill Cemetery, Caldwell, Idaho

DATE REC'D BY LOCAL REGISTRAR: Aug. 28, 1967
REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: Merville D. Davis
LICENSE NO.: E-399
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
SEP 19 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3492
Local Reg. No. 77
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Canyon 141 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakley's Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 140

b. COUNTY: Canyon

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma 11

d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lenora	Holding	Durrant	Aug. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	July 18, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Spanish Fork, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas Clayton Holding — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Lovina Pollard — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: X [signature] ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4221

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiovascular Accident — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-19-63, 19____, *to* 8-18-67, 19____, *that I last saw the deceased alive on* 8-17-67, 19____, *and that death occurred at* 3:13A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
250 W [signature]		222 East Elm--Caldwell, Idaho	8-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Aug. 19, 1967	Salt Lake City Cemetery	Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 18, 1967	Mrs. Martha Walmsley	Merville D. Davis	E-399

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3493
Local Reg. No. 45
Reg. Dist. No. 360

BIRTH NO.

RECEIVED AUG 28 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 149
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 880
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 061

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 370
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ray	Thomas	Moreland	August 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct. 28, 1888	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29		Creston, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J. E. Moreland	Ohio	Lenna Bason	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	War I 3	519-44-3387	X Verna G. Moreland	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bronchogenic Ca c Hepatic — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) metastases & mediastinal
DUE TO (c) recurrence

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. metastases

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-1-66	Bronchogenic Ca rt. lung c mediastinal	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-22, 1966, *to* 8-19-67, 19___, *that I last saw the deceased alive on* 8-18-67, 19___, *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John R. Nelson 389	M.D.	303 E. Logan Caldwell, Idaho	8-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 22, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 24, 1967	Mrs. Martina Walmsley	Merville D. Davis	E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 29 1967

SEP 11 1967

JAN 30 1968

NOV 17 1986

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3494
Local Reg. No. 48
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 370
b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bruneau
d. STREET ADDRESS (If rural, give location) Box 132

3. NAME OF DECEASED (Type or Print)
a. (First) Samuel
b. (Middle) M.
c. (Last) King

4. DATE OF DEATH (Month) (Day) (Year) August 19, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 21, 1902
9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Albany, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Morris King — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Jennie Hogul — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-10-0070
17. INFORMANT'S OWN SIGNATURE x Mrs Edith King — ADDRESS

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Coronary — 6 hr
DUE TO (c) A S H D — 6 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 18, 1967, *to* Aug 19, 1967, *that I last saw the deceased alive on* Aug 19, 1967, *and that death occurred at* 4:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 437 (Degree or title) Neil E Rogers [illegible]
23b. ADDRESS Caldwell Idaho
23c. DATE SIGNED 8/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Aug. 19, 1967
24c. NAME OF CEMETERY OR CREMATORY Bruneau Cemetery
24d. LOCATION (City, town, or county) (State) Bruneau, Idaho

DATE REC'D BY LOCAL REG. Aug. 28, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Merville D Davis
LICENSE NO. E-394

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell. Ida.

SEP 1 1967

SEP 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
AUG 25 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3495
Local Reg. No. 43
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 CANYON 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
c. LENGTH OF STAY (in this place) 2 WKS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 011
b. COUNTY ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 5605 COFFEE

3. NAME OF DECEASED (Type or Print) a. (First) EDNA b. (Middle) c. (Last) BROADHURST

4. DATE OF DEATH (Month) (Day) (Year) AUGUST 21, 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: AUG. 15, 1893
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME MAKER 01
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): TWIN GROVES, IDAHO
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: DAVID GODFREY — BIRTHPLACE: UTAH
14. MOTHER'S MAIDEN NAME: LORETTA McINTRYE — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Wm. C. Broadhurst — ADDRESS: BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Left hydronephrosis — 3 Months
DUE TO (c) Gastro-intestinal hemorrhage — 1 week

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Ca of left ureter

19a. DATE OF OPERATION: 8/5/67
19b. MAJOR FINDINGS OF OPERATION: 1) Ca of left ureter 2) Secondary left hydronephrosis
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1956, *to* Aug 21, 1967, *that I last saw the deceased alive on* Aug 21, 1967, *and that death occurred at* 10:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] 459 (Degree or title) MD FACS
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 8-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: 8-22-67
24c. NAME OF CEMETERY OR CREMATORY: PARKER
24d. LOCATION (City, town, or county) (State): PARKER, IDAHO

DATE REC'D BY LOCAL REG.: Aug. 24, 1967
REGISTRAR'S SIGNATURE: Mae Martin Walmsley
25. EMBALMER: M. B. Shepherd — LICENSE NO. 473
FIRM NAME: HANSEN FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 1 2 1990

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3496
Local Reg. No. 46
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 CANYON 127
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA,
c. LENGTH OF STAY (in this place) 27 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1706 ist. ST. SO. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 142 b. COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA, IDAHO
d. STREET ADDRESS (If rural, give location) 1706 IST. ST. SO.

3. NAME OF DECEASED (Type or Print)
a. (First) FRANCE b. (Middle) B. c. (Last) KUDEBEH

4. DATE OF DEATH (Month) AUG (Day) 21, (Year) 1967

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2
8. DATE OF BIRTH NOV 13, 1878
9. AGE (In years last birthday) 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 01
10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE
11. BIRTHPLACE (State or foreign country) WEVER, IOWA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HALSEY BUCK BIRTHPLACE SWITZERLAND CO. IND
14. MOTHER'S MAIDEN NAME ATTICA ANDERSON BIRTHPLACE FT. MADISON, IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 483-26-1080T
17. INFORMANT'S OWN SIGNATURE X Halsey F. Kudebeh ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Found dead about 1:50 pm.

22. *I hereby certify that I attended the deceased from* Inspection only, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Henry C. Wesche 583 MD. Coroner 4 (Degree or title)
23b. ADDRESS NAMPA, IDAHO
23c. DATE SIGNED 8-24-67.

24a. BURIAL, CREMATION, REMOVAL (Specify) 3 REMOVAL
24b. DATE 8-24-67
24c. NAME OF CEMETERY OR CREMATORY MONTROSE CEMETERY
24d. LOCATION (City, town, or county) (State) MONTROSE, IOWA

DATE REC'D BY LOCAL REG. Aug. 25, 1967
REGISTRAR'S SIGNATURE Mae Martin Walmsley
25. EMBALMER [signature] B. Shepherd
LICENSE NO. 473

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHEP HERD MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3497
Local Reg. No. 49
Reg. Dist. No. 360

RECEIVED AUG 30 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 251

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 2505 Washington

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Emma	(NMI)	Newport	August 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	July 28, 1883	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Payson, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Smith Wegnall	England	Mary Elizabeth Kendall	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	[illegible] Newport	Boise Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug, 19 67, *to* Aug 21, 19 67, *that I last saw the deceased alive on* Aug 21, 19 67, *and that death occurred at* 1:30 A m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert H. Jensen 258 MD	Robert H. Jensen, M.D. 222 EAST LOGAN	8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	[illegible], or county) (State)
Burial	Aug. 24, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 28, 1967	Mrs. Martin Walmsley	Merrill D Davis	E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 22 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 7 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3498
Local Reg. No. 56
Reg. Dist. No. 360

RECEIVED SEP 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 — 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA — LENGTH OF STAY (in this place): 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL — 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO — 328 — b. COUNTY: OWYHEE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL MARSING
d. STREET ADDRESS (If rural, give location): ROUTE 1

3. NAME OF DECEASED (Type or Print): a. (First) KARL — b. (Middle) IVAN — c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year): AUGUST 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED 3	SEPT. 22, 1906	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED SHEET METAL — 10b. KIND OF BUSINESS OR INDUSTRY: U.P. RAIL ROAD
11. BIRTHPLACE (State or foreign country): POCATELLO, IDAHO
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: BENJAMIN F. SMITH — BIRTHPLACE: NO RECORD
14. MOTHER'S MAIDEN NAME: CLARA STAMMEN — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) 1924 to 1927
16. SOCIAL SECURITY NO. 712-07-0383
17. INFORMANT'S OWN SIGNATURE: Leona Smith — ADDRESS: Marsing

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Squamous Cell Carcinoma
DUE TO (c) of Bladder

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1963, *to* Aug, 1967, *that I last saw the deceased alive on* Aug 24, 1967, *and that death occurred at* 7:15P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Landon Olson, MD — (Degree or title) 115
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 9/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 8-28-67
24c. NAME OF CEMETERY OR CREMATORY: GLENN REST CEMETERY
24d. LOCATION (City, town, or county) (State): GLENNS FERRY, IDAHO

DATE REC'D BY LOCAL REG.: Sept. 5, 1967
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: M B Shepherd
LICENSE NO. 473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 19 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3499
Local Reg. No. 54
Reg. Dist. No. 360

RECEIVED SEP 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 — LENGTH OF STAY (in this place): 000
b. CITY OR TOWN (If outside corporate limits or township): Caldwell
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 05

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141 — b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1601 Blaine St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Julia	C.	McDonald	August 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	January 8, 1900	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Teacher 12		Butler, Johnson Co., Tenn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Crosswhite	Tenn.	Eugenia Barry	Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	357-26-8714	[illegible] Douglas McDonald	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia & hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cancer Colon c Metastasis — 6 mo
(c) Pelvic Spread & Ureteral Obstruct — 1 mo

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Metastasis to lungs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
21 Mar 67	Pelvic metastasis of Colon cancer	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct, 1966, *to* 24 Aug, 1967, *that I last saw the deceased alive on* 24 Aug, 1967, *and that death occurred at* 9:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[illegible] Thompson 423	M.D.	Caldwell	29 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 28, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 1, 1967	Mrs. Martina Walmsley	Rodney W Dakan	E-508

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3500
Local Reg. No. 53
Reg. Dist. No. 360

Certificate of Death

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF [illegible]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 620-11 Ave. So. Ext.

3. NAME OF DECEASED (Type or Print)
a. (First) MAGGIE
b. (Middle) A.
c. (Last) ROBINSON

4. DATE OF DEATH (Month) August (Day) 24, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 20, 1874
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Defiance Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Isiah Ridenour — BIRTHPLACE: Maryland
14. MOTHER'S MAIDEN NAME: Annie E. Flaugher — BIRTHPLACE: Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 54 8966J1
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Melba, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

170X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of breast — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile Changes — 3 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1-, 1961, *to* 8-24-, 1967, *that I last saw the deceased alive on* 8-24, 1967, *and that death occurred at* 3:00 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Gerald E. Nesche 559 M.D. (Degree or title) 1
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: Aug. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Thomas Cemetery
24d. LOCATION (City, town, or county): Thomas (State): Oklahoma

DATE REC'D BY LOCAL REG.: Sept. 1, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature]
LICENSE NO.: E-496
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3501
Local Reg. No. 57
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 1-28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 28 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1703 6th STREET. SO. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 142
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 1703 6th STREET SO.

3. NAME OF DECEASED (Type or Print)
a. (First): JESUS
b. (Middle): C.
c. (Last): SERRATOS

4. DATE OF DEATH (Month) (Day) (Year): AUGUST 24, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: DEC. 25, 1897
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED LABOR 06
10b. KIND OF BUSINESS OR INDUSTRY: P.F.E.
11. BIRTHPLACE (State or foreign country): ARANDAS MEXICO
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: THEODORE SERRATOS — BIRTHPLACE: MEXICO
14. MOTHER'S MAIDEN NAME: RAFALITA CONSILION — BIRTHPLACE: MEXICO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 570-10-0685
17. INFORMANT'S OWN SIGNATURE: X Ralph Serratos — ADDRESS: NAMPA

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infant Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) [illegible] & hypertension — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1953, to Aug, 1967, that I last saw the deceased alive on Aug 17, 1967, and that death occurred at ___ p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Graydon Crowe 115
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 8-26-67
24c. NAME OF CEMETERY OR CREMATORY: MT. CALVARY CEMETERY
24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Sept. 5, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd — LICENSE NO. 473

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: SHEPHERD MORTUARY

DUTIES:

SEP 8 1967

JUN 25 1984

FEB 27 1991

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3502
Local Reg. No. 50
Reg. Dist. No. 360

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1402 Rim View Dr.

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) W. c. (Last) Zink
4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 16, 1900
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Printer
10b. KIND OF BUSINESS OR INDUSTRY 21
11. BIRTHPLACE (State or foreign country) Naper, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph B. Zink BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Harriett E. Schaeffer BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) War I 3
16. SOCIAL SECURITY NO. 519-09-0829
17. INFORMANT'S OWN SIGNATURE + Mrs. R. W. Zink ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 10 mnts

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A S H D — 10 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. M. S. — 15 yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1963, *to* Aug, 1967, *that I last saw the deceased alive on* Aug 24, 1967, *and that death occurred at* 9:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Hal S Reynolds 437 (Degree or title) MD
23b. ADDRESS Caldwell Idaho
23c. DATE SIGNED 8/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Aug. 31, 1967
REGISTRAR'S SIGNATURE Mrs. Martine Walmsley
25. EMBALMER Melville D Dakin
LICENSE NO. E-399
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Physician, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 16 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3503
Local Reg. No. 58
Reg. Dist. No. 360

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 140 SEP 6 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural—Murphy
c. VENUE OF STAY (in this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6 miles South of Snake River Hiway 45

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 370 b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) P. O. Box 516

3. NAME OF DECEASED (Type or Print) a. (First) Floribel b. (Middle) Bergh 000 c. (Last) Williams

4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH June 21, 1894
9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Agustavas A. Bergh BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Sarah Jane Poynes BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Yes
17. INFORMANT'S OWN SIGNATURE M. Ned Williams ADDRESS

18. CAUSE OF DEATH 8234
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken neck.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) auto accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Scalp laceration — Chest Contusion

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) on highway 06
21c. (CITY, TOWN, OR TOWNSHIP) Hiway 45 13 370 (COUNTY) Owyhee (STATE) Idaho.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 25 — 1967 5 P. m. 2
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car left road and turned over.

22. *I hereby certify that I attended the deceased from* Dead on arrival Mercy Hospital — Nampa Idaho *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Henry C Wesche M.D. 583 (Degree or title) Coroner. 4
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 8-29-67.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park
24d. LOCATION (City, town, or county) Boise, (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 5, 1967
REGISTRAR'S SIGNATURE Mrs Martina Walmsley
25. EMBALMER G. W. Waters G W Waters
LICENSE NO. E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 6 1983

JAN 1 8 1989

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 1 1991

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

FEB 2 3 1999

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3504
Local Reg. No. 60
Reg. Dist. No. 360

Certificate of Death

RECEIVED SEP 11 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, 1201 Elgin St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1201 Elgin St.

3. NAME OF DECEASED (Type or Print)
a. (First): Franklin
b. (Middle): E. Youngblood
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): August 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: March 17, 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Colorado
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph P. Youngblood — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Martha M. Suttle — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-26-8215
17. INFORMANT'S OWN SIGNATURE: X John W Youngblood — ADDRESS:

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* found dead at 3:30 PM on 8-25-67 *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 583 (Degree or title): Henry C Wesche Md. Coroner 4
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 5, 1967
REGISTRAR'S SIGNATURE: Mrs Martin Walmsley
25. EMBALMER: Merville D. Davis
LICENSE NO.: E-399

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED SEP 5 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3505
Local Reg. No. 52
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1712 Dearborn St.

3. NAME OF DECEASED (Type or Print)
a. (First) AMY
b. (Middle)
c. (Last) MITCHELL

4. DATE OF DEATH (Month) 8 (Day) 25 (Year) 67

5. SEX F
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 1/8/1874
9. AGE (In years last birthday) 93 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Decatur, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Kirkbride — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME no record — BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-26-9266B
17. INFORMANT'S OWN SIGNATURE V.R. Mitchell — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

170X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Cancer

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cancer of breast

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1950 *to* 8/26, 1967, *that I last saw the deceased alive on* 8/24, 1967, *and that death occurred at* 10:45 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE 454 (Degree or title) J.O. Saltzer MD
23b. ADDRESS Nampa
23c. DATE SIGNED 8/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/29/67
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) Nampa Canyon Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 1, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Jos Winspeare — LICENSE NO. E496

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3506
Local Reg. No. 51
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 807-8 Avenue South

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Myrtle	L.	Keck		8	26	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	White	Married 2	9/15/1897	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. School Teacher 12	High School	Odebolt Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Keck	Pennsylvania	Laura Jane	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	472 14 0044A	Ortan L. Keck	807-8 Ave. So. Nampa, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma Breast
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1950 19__, *to* Aug. __, 19 67, *that I last saw the deceased alive on* 8/26, 1967, *and that death occurred at* 6:45A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
454 [illegible] MD	Nampa, Idaho	8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 30, 1967	Hillcrest Cemetery	Canyon County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 1, 1967	Mrs. Martina Walmsley	[illegible]	E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 6 1984

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3507
Local Reg. No. 65
Reg. Dist. No. 360

Certificate of Death

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LIVING STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): 324 Freeport

3. NAME OF DECEASED (Type or Print)
a. (First): ALTA
b. (Middle): A 051
c. (Last): FREDRICK

4. DATE OF DEATH (Month) 8 (Day) 26 (Year) 67

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 5/6/1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months 3, Days 20 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Ponca, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Carnell — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Isabel Beeson — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 503-12-81540
17. INFORMANT'S OWN SIGNATURE: Opal Meseness — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Metastatic carcinoma of rectum — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

154X

19a. DATE OF OPERATION: 5-5-67
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of rectum
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-4-67, *19*__, *to* 8-26-67, *19*__, *that I last saw the deceased alive on* 8-26-67, *19*__, *and that death occurred at* 6:00p. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A M Lanning M.D. 425
23b. ADDRESS: 227 E. Logan, Caldwell, Idaho
23c. DATE SIGNED: 9-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 8/30/67
24c. NAME OF CEMETERY OR CREMATORY: Kuna
24d. LOCATION (City, town, or county) (State): Kuna, Idaho

DATE REC'D BY LOCAL REG.: Sept. 7, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3508
Local Reg. No. 59
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 6 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: CANYON 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CALDWELL
c. LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CALDWELL MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 140
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL NAMPA
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) RALPH b. (Middle) EDGAR c. (Last) FINLEY

4. DATE OF DEATH (Month) (Day) (Year): AUG. 28, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED 4
8. DATE OF BIRTH: APRIL 1, 1927
9. AGE (In years last birthday): 40 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MAINT. MAN 09
10b. KIND OF BUSINESS OR INDUSTRY: ADA HIGHWAY DEPT.
11. BIRTHPLACE (State or foreign country): HUSTON, IDAHO
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES W. FINLEY — BIRTHPLACE: NO RECORD
14. MOTHER'S MAIDEN NAME: ELOUISE McCALL — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WES (If yes, give war or dates of service): W W II
16. SOCIAL SECURITY NO.: 518-26-8664
17. INFORMANT'S OWN SIGNATURE: Elouise Finley — ADDRESS: NAMPA, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Broken neck & multiple skull fractures.
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): auto accident
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) 555 (COUNTY) (STATE): near Adrian 38 Malheur Oregon.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 28 1967 m. 0
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?: Car overturned on gravel road.

22. *I hereby certify that I attended the deceased from* Inspection only, 19—, *to* ——, 19—, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* —— m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wesche M.D. Coroner 583
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 9-5-67
24c. NAME OF CEMETERY OR CREMATORY: CANYON HILL CEMETERY
24d. LOCATION (City, town, or county) (State): CALDWELL, IDAHO

DATE REC'D BY LOCAL REG.: Sept. 5, 1967
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: R. B. Shepherd
LICENSE NO.: 473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 15 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3509
Local Reg. No. 55
Reg. Dist. No. 360

RECEIVED
SEP 6 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN: Nampa
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Midland Manor

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Mattie	Alice	Cotterell	August 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	July 25, 1885	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Teacher 12	Teaching	Hutchinson, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Todd Easley	[illegible]ford	Sally Lee Bracken	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-46-9740T	Mrs. A. Cotterell	Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	INTERVAL BETWEEN ONSET AND DEATH
	Coronary occlusion	1 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) ruptured peptic ulcer	4 days
	DUE TO (c)	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/24, 1967, *to* 8/28, 1967, *that I last saw the deceased alive on* 8/28, 1967 *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
S. C. Tabb	534 MD	619 Canyon Nampa	8/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 31, 1967	American Falls Cemetery	American Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 5, 1967	Mrs. Martina Walmsley	Boyle Sinclair	E-496

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

DUTIES:

SEP 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3510
Local Reg. No. 62
Reg. Dist. No. 360

RECEIVED SEP 1 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa Rural Rte. #4
d. STREET ADDRESS (If rural, give location) Route #4

3. NAME OF DECEASED (Type or Print) a. (First) Oren b. (Middle) A. c. (Last) Marbeiter

4. DATE OF DEATH (Month) (Day) (Year) Aug. 29, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 31, 1895

9. AGE (In years last birthday) 72 72
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carmen 10

10b. KIND OF BUSINESS OR INDUSTRY Railroad

11. BIRTHPLACE (State or foreign country) Baroda, Michigan

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Anthony Marbeiter
BIRTHPLACE Canada

14. MOTHER'S MAIDEN NAME Nora Kirkman
BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.I 3

16. SOCIAL SECURITY NO. 700-09-3441

17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH 6 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD — 10 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Emphysema — 10 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1967 to Aug, 1967, that I last saw the deceased alive on Aug 29, 1967, and that death occurred at 11:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE [signature] (Degree or title) MD 115

23b. ADDRESS Nampa Ida

23c. DATE SIGNED 9/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 2, 1967

24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery

24d. LOCATION (City, town, or county) Ada County (State) Idaho

DATE REC'D BY LOCAL REG. Sept 6 1967

REGISTRAR'S SIGNATURE Mrs Martin Walmsley

25. EMBALMER Richard W. Mesenbrink

LICENSE NO. E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 15 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED SEP 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3511
Local Reg. No. 61
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 057

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 2420 College Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Wade	(NMI)	Ross	Aug. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Oct. 21, 1882	84	10	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Leonard, Texas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Wade Ross	Unknown	Ellen Grant	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	570-34-7612	X Palmer Ross	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4281

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis 6 weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-5, 1967, *to* 8-29-67, 1967, *that I last saw the deceased alive on* 8-29, 1967, *and that death occurred at* 5:40A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D. 166	Caldwell Idaho	8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Aug. 30, 1967	Inglewood Cemetery	Inglewood, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 5, 1967	Mrs Martina Walmsley	Merrill D Davis	E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. He shall further state the cause of death, so as to show the course of disease or sequence of [redacted] resulting in death, giving the primary cause, and also the contributory causes, if any, and [redacted] tion of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or condi[redacted] sulting from disease, will not be held sufficient for issuing a burial or removal permit; and any [redacted] cate containing only such terms as defined by the state registrar as indefinite and unsat[redacted], shall be returned to the physician for correction and definition. The international cl[redacted] tion of the causes of death shall be used by all physicians in stating the cause of death in [redacted] cal certificate. Causes of death, which may be the result of either disease or violence, shall [redacted] fully defined; and if from violence, its nature shall be stated, and whether (probably) ac[redacted], suicidal, or homicidal.

ADDITIONAL REMARKS by Physician [redacted]

State File No. 3512
Local Reg. No. 64
Reg. Dist. No. 360

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 370
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing
d. STREET ADDRESS (If rural, give location): Box 104

3. NAME OF DECEASED (Type or Print)
a. (First): Cora
b. (Middle): P.
c. (Last): Bledsoe

4. DATE OF DEATH (Month) (Day) (Year): Aug. 30, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 30, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Grove Springs, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Prock — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: ~~xxxxxx~~ Francis Summers — BIRTHPLACE: North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-60-6597
17. INFORMANT'S OWN SIGNATURE: x James W. Bledsoe — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

241X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH: 7-21-67 to 8-30-67

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) "or pulmonary"
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Generalized anterosclerosis post Ab. CVA

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-21, 1967, *to* 8-30, 1967 *that I last saw the deceased alive on* 8-30, 1967, *and that death occurred at* 5:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 160
23b. ADDRESS: Caldwell Ida
23c. DATE SIGNED: 9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 7, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D. Davis
LICENSE NO.: E-399

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 29 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 06 1995

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 12 1998

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 31 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3513
Local Reg. No. 3
Reg. Dist. No. 520-521

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou 150 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 150
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
d. STREET ADDRESS (If rural, give location): 140 East Hooper Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) 069 c. (Last): Lynn Alvin Wright

4. DATE OF DEATH (Month) (Day) (Year): August 18, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: May 9, 1905
9. AGE (In years last birthday): 62 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder-retired 21
10b. KIND OF BUSINESS OR INDUSTRY: J.R.Simplot Co.
11. BIRTHPLACE (State or foreign country): Delta, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Benjamin Wright — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Dora Christensen — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 548-07-5691
17. INFORMANT'S OWN SIGNATURE: Anna V. Wright — ADDRESS: Soda Springs, Ida

18. CAUSE OF DEATH 9030
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Laceration of Pleura + Subcutaneous emphysema — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture ribs — 3 Days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Soda Springs 13 150 Caribou Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 14 1967 4 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Slipped + fell in living room

22. *I hereby certify that I attended the deceased from* 8-14, 1967, *to* 8-17, 1967, *that I last saw the deceased alive on* 8-16, 1967, *and that death occurred at* 1125 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Russell Tigert 535 (Degree or title) MD
23b. ADDRESS: Soda Springs Idaho
23c. DATE SIGNED: 8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/21/67
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: 8-30-67
REGISTRAR'S SIGNATURE: Darhl Cheirrett
25. EMBALMER: Theodore S Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

DUTIES:

SEP 5 1967

FEB 7 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3514
Local Reg. No. 7
Reg. Dist. No. 520-521

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 31 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Caribou 150 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Caribou Co. Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 040
b. COUNTY: Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dingle
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Clifford
b. (Middle): Frank
c. (Last): Linford

4. DATE OF DEATH (Month) (Day) (Year): Aug. 14 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Sept. 24, 1903
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & steel worker
10b. KIND OF BUSINESS OR INDUSTRY: Ref-Chem Constr.Co
11. BIRTHPLACE (State or foreign country): Wahi, New Zealand
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joseph W. Linford 04 — BIRTHPLACE: Logan, Utah
14. MOTHER'S MAIDEN NAME: Lois E. Ricks — BIRTHPLACE: Paris, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-10-2507
17. INFORMANT'S OWN SIGNATURE: Mrs. Clifford Linford — ADDRESS: Dingle, Idaho.

18. CAUSE OF DEATH 9023
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Fracture of cervical spine / Internal chest injury — INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Monsanto Plant 03
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Soda Springs 13 & Caribou 150 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 14, 1967 1 P m. 2
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Working on furnace + fell to bottom of the furnace.

22. *I hereby certify that I attended the deceased from* DOA *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Russell Tigert 535 MD
23b. ADDRESS: Soda Springs, Idaho
23c. DATE SIGNED: 8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Dingle Cemetery
24d. LOCATION (City, town, or county) (State): Dingle, Bear Lake, Idaho

DATE REC'D BY LOCAL REG.: 8-18-67
REGISTRAR'S SIGNATURE: Darhl Cheirrett
25. EMBALMER: Nile Matthews
LICENSE NO.: E 359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 18 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3515
Local Reg. No. 2
Reg. Dist. No. 520-521

RECEIVED AUG 31 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou 150 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou County Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 150
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
d. STREET ADDRESS (If rural, give location): 151 East First North

3. NAME OF DECEASED (Type or Print)
a. (First): NELLIE
b. (Middle): C.
c. (Last): LUNDGREN

4. DATE OF DEATH (Month) August (Day) 16 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 1, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife, retired
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): French Grove, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Josiah Cutter 01 — BIRTHPLACE: No record
14. MOTHER'S MAIDEN NAME: Margaret O'Flatterty — BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-44-4894
17. INFORMANT'S OWN SIGNATURE: Bruce A. Lundgren — ADDRESS: Pleasant Grove, Utah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

334X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Encephalopathy due to hypertension — INTERVAL BETWEEN ONSET AND DEATH: 11 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-5, 1967, *to* 8-16, 1967, *that I last saw the deceased alive on* 8-15, 1967, *and that death occurred at* 1:15A. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Bruce Tigert 535 (Degree or title): M. D.
23b. ADDRESS: Soda Springs, Idaho
23c. DATE SIGNED: 8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: New Sweden Cemetery
24d. LOCATION (City, town, or county) (State): Bonneville County Idaho

DATE REC'D BY LOCAL REG.: 8-25-67
REGISTRAR'S SIGNATURE: Darhl Cherrett
25. EMBALMER: Orland C. Buck
LICENSE NO.: E-250

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

DUTIES:

OCT 2 5 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3516
Local Reg. No. 4
Reg. Dist. No. 520-521

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
c. LENGTH OF STAY (in this place): 800
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 150
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
d. STREET ADDRESS (If rural, give location): 735 East Hooper Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Richard Deon Hoopes
b. (Middle): 069
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): August 29, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: June 18, 1949
9. AGE (In years last birthday): 18 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tapper 21
10b. KIND OF BUSINESS OR INDUSTRY: Monsanto Co.
11. BIRTHPLACE (State or foreign country): Soda Springs, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Jack Hoopes — BIRTHPLACE: Grace, Idaho
14. MOTHER'S MAIDEN NAME: Beth Lowe — BIRTHPLACE: Soda Springs, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-60-7092
17. INFORMANT'S OWN SIGNATURE: x Jack Hoopes — ADDRESS: Soda Springs, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8101

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Depressed Skull fracture — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Rail road crossing 10
21c. (CITY, TOWN, OR TOWNSHIP) 13 Soda Springs — (COUNTY) 150 Caribou — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 29, 1967 10:30 p.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Thrown from his car when he ran into the side of a freight train.

22. *I hereby certify that I attended the deceased from* 8-29 2, 1967, *to* 8-29, 1967, *that I last saw the deceased alive on* 8-29, 1967, *and that death occurred at* 11 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Russell Tigert MD 535
23b. ADDRESS: Soda Springs Idaho
23c. DATE SIGNED: 9/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/1/67
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: 9-12-67
REGISTRAR'S SIGNATURE: Darhl Cherrett
25. EMBALMER: Theodore S Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3517
Local Reg. No. 1736
Reg. Dist. No. 470

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia (16) 3-08
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
STATISTICAL OF STAY (in this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 340 b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paul
d. STREET ADDRESS (If rural, give location): 327 W. Lincoln

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Earl	Henry 009	Haynes	August 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Jan. 24, 1894	73	6	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04	Farming	Hooper, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Haynes,	Durby, England	Louisa Johnson,	Fountain Green, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	— — — —	518-42-6674	Margaret M. Haynes	Rt Box 3 Paul Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 48 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 5-8 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-17-50, 19__, *to* 8-5-67, 19__, *that I last saw the deceased alive on* 8-5-67, 19__, *and that death occurred at* 3:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Orland M. Burch	526 MD	Burley, Idaho	8-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 8, 1967	Paul Cemetery	Paul, Minidoka Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 14 1967	Beck A. Pearson	Orland M Burch	E-471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person~~ has resided in the county where ~~death occurred~~ for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

67882

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics

State File No. 3518
Local Reg. No. 1742
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Cassia (161) — SEP 5 1967 — 1-09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley — STAY (in this place): 9 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION: Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho (16) — b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1729 Miller Avenue

3. NAME OF DECEASED (Type or Print) — a. (First): Inez — b. (Middle): 069 — c. (Last): Keel

4. DATE OF DEATH (Month) (Day) (Year): Aug. 8, 1967

5. SEX: Female — 6. COLOR OR RACE: White — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 2

8. DATE OF BIRTH: Feb. 19, 1882 — 9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01 — 10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Geff, Illinois — 12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: James Marion Richards — Illinois

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Harriet Bobbett — Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-60-3115

17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Everett, Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): ? Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS: ? cholelithiasis — gen. arteriosclerosis

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) — 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) — 21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-21, 1967, *to* 8-8, 1967, *that I last saw the deceased alive on* 8-7, 1967, *and that death occurred at* 1:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) — 23b. ADDRESS: Burley Ida — 23c. DATE SIGNED: 8-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal — 24b. DATE: 8/31/1967 — 24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery — 24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Aug 31. 1967 — REGISTRAR'S SIGNATURE: Ruth A. Pearson — 25. EMBALMER: [signature] — LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3519
Local Reg. No. 1737
Reg. Dist. No. 470

BIRTH NO.

RECEIVED AUG 18 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia 160 1-59
b. CITY OR TOWN: Malta
LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 160
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malta
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Shirley b. (Middle) H c. (Last) Barlow

4. DATE OF DEATH (Month) (Day) (Year): Aug 10, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 24, 1908

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station Operator

10b. KIND OF BUSINESS OR INDUSTRY: Oil

11. BIRTHPLACE (State or foreign country): Grouse Creek, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Smith Barlow
BIRTHPLACE: Fairfield, Ut.

14. MOTHER'S MAIDEN NAME: Elizabeth Hansen
BIRTHPLACE: Brigham City, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): — — — —

16. SOCIAL SECURITY NO.: 519-22-2508

17. INFORMANT'S OWN SIGNATURE: Irene S. Barlow
ADDRESS: Malta, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Probable Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease Severe. — 9 years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

Investigated the death of

23a. SIGNATURE: Leslie L Fillmore MD 583 (Degree or title) Coroner

23b. ADDRESS: Box 657 Burley Idaho

23c. DATE SIGNED: 9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/14/67

24c. NAME OF CEMETERY OR CREMATORY: Malta Cemetery

24d. LOCATION (City, town, or county) (State): Malta, Idaho

DATE REC'D BY LOCAL REG.: Aug 14, 1967

REGISTRAR'S SIGNATURE: Beth H. Pearson

25. EMBALMER

LICENSE NO.: E 389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3520
Local Reg. No. 1738
Reg. Dist. No. 470

BIRTH NO.

RECEIVED AUG 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia 161 1-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burley Nursing Home 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 161
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1729 Miller Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry	Kilby	Clegg	August 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	March 24, 1884	83	4	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Heavy Equip. Operator	Construction	Downey, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Clegg,	England	Mary Van Noy	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE	ADDRESS
No	— — — —	529-07-3024A	X Lona C. Campbell	R#2 Rupert Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Thrombosis 3338	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Arteriosclerotic Heart Disease	5 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-30, 1967, *to* 8-10, 1967, *that I last saw the deceased alive on* Aug 10, 1967, *and that death occurred at* 1:30 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richer 283	MD	Burley Idaho	8-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Remov.-Bur.	Aug. 14, 1967	Salt Lake City Cemetery	Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 15, 1967	Beth H. Pearson	Ormand J. Burch	E-471

FIRM NAME: McCULLOCH FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3521
Local Reg. No. 1740
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161 1-52
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): 52 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 161
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sarah
b. (Middle): 070
c. (Last): Elquist

4. DATE OF DEATH (Month) (Day) (Year): August 16, 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Jan. 31, 1882

9. AGE (In years last birthday): 85
IF UNDER 1 YEAR — Months: 6 Days: 16
IF UNDER 24 HRS. — Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Grantsville, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Bell
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Jane Brown
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-18-2379A

17. INFORMANT'S OWN SIGNATURE: Mrs Glen Arthur
ADDRESS: R-2 Box 64 Paul Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inanition due to arteriosclerotic enceph- alopathy, severe. — INTERVAL BETWEEN ONSET AND DEATH: 5-6 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis, senility — 10-15 years
DUE TO (c) Diabetes mellitus — 10-15 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* October 17 1950, *to* August 16, 1967, *that I last saw the deceased alive on* August 16, 1967, *and that death occurred at* 5:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: Snow Bldg. Burley, Idaho
23c. DATE SIGNED: 8-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 19, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Aug 29-1967
REGISTRAR'S SIGNATURE: Bert N. Pearson
25. EMBALMER: Ormand J Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

DUTIES:

OCT 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 6 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 3 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3522
Local Reg. No. 1739
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 48 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 161
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1729 Miller Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Bertha
b. (Middle): Mae
c. (Last): Bancroft Shockey

4. DATE OF DEATH (Month) (Day) (Year): Aug. 17, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 31, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Sioux Falls, So. Dakota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles H. Bancroft — BIRTHPLACE: (Unknown)
14. MOTHER'S MAIDEN NAME: Rose Whitney — BIRTHPLACE: New York State

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: 518-12-5800
17. INFORMANT'S OWN SIGNATURE: Russell B. Shockey — ADDRESS: Burley

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1 Month

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Generalized Arteriosclerosis — 5-8 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Previous Surgery c̄ Aortic graft for abdominal Aneurysm

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-10-47, 19___, *to* 8-17-67, 19___, *that I last saw the deceased alive on* 8-16-67, 19___, *and that death occurred at* 1:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 526 MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 19 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/19/1967
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Aug 25 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3523
Local Reg. No. 1741
Reg. Dist. No. 470

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161 1-55
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): 55 Years

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 161
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital
d. STREET ADDRESS (If rural, give location): 1729 Miller Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Narian; b. (Middle) 010; c. (Last) Singh

4. DATE OF DEATH: (Month) August (Day) 23, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: Hindu

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 1884

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): India

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - -

16. SOCIAL SECURITY NO. 519-44-7787A

17. INFORMANT'S OWN SIGNATURE: A R Salmon
ADDRESS: 1835 Overland, Burley, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia associated with
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute severe Myocardial failure
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 3 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Uremia, pyelonephritis, Diabetes mellitus, arteriosclerotic Cardiovascular disease

Duration Indefinite

493X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-21, 1967, *to* 8-23, 1967, *that I last saw the deceased alive on* 8-23, 1967, *and that death occurred at* 9:55 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ormond Bench (Degree or title) 012

23b. ADDRESS: Burley, Idaho

23c. DATE SIGNED: 8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Aug. 25, 1967

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery

24d. LOCATION (City, town, or county) (State): Burley Idaho

DATE REC'D BY LOCAL REG.: Aug. 29 1967

REGISTRAR'S SIGNATURE: Bess H. Pearson

25. EMBALMER: Ormond Bench

LICENSE NO.: E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3524
Local Reg. No. 1743
Reg. Dist. No. 470

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
SEP 11 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia (16) 1-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF RESIDENCE (In this place): 2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho (16)
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Declo
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Carl
b. (Middle): Christian (070)
c. (Last): Behr

4. DATE OF DEATH: (Month) Aug. (Day) 24, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Jan 27, 1878

9. AGE (In years last birthday): 89
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (04)

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Holstein, Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Peter Behr
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Magdalena Mohr
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-28-0300

17. INFORMANT'S OWN SIGNATURE: Chesto H. Behr
ADDRESS: Declo, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro-vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebro sclerosis — 20 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1967 *to* Aug 24, 1967, *that I last saw the deceased alive on* Aug 24 1967 *and that death occurred at* 20 m., *from the causes and on the date stated above.*

23a. SIGNATURE: John H. Pearson M.D. (135) (Degree or title)
23b. ADDRESS: Box 848 Burley Idaho
23c. DATE SIGNED: Aug 25 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/28/1967
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Sept 6 1967
REGISTRAR'S SIGNATURE: Burt H. Pearson
25. EMBALMER: Garth Payne
LICENSE NO.: E 389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3525
Local Reg. No. 660
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 29 1967 000 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clark 170
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 5½ Miles So. of Dubois
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Interstate Hywy # 15 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Pend Oreille 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Metaline Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LYLAH	SAPPHIRE	ODDEN	August 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	January 4, 1916	51				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Volt, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lyle Elton Clarke	Iowa	Blenda Sapphire Peterson	Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	Not Avail.	C. C. Odden, Jr.	Ogden, Utah

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple injuries to body and head — INTERVAL BETWEEN ONSET AND DEATH: Instantly

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident 1	Interstate Hwy 15 06	(Rural) 13 Dubois 170	Clark	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Aug. 16 1967 6:20 p.m. 2	WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2	Struck by wheels of Semi

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 Morris H. Tavenner	Coroner 4	Dubois, Idaho	Aug. 22, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal (air) 3	8/17/67	Havre Cemetery	Havre, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 22, 1967	Lynn D. Tavenner	Jack A. Wood, Jr.	396

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3526
Local Reg. No. 660
Reg. Dist. No.

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clark 170 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 5½ Miles So. of Dubois
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Interstate Hywy # 15 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48 b. COUNTY Pend Oreille 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Metaline Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NORMAN	ROALD	ODDEN	August 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 12, 1912	55				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Master Mechanic 11
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Wyndmere, North Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ole H. Odden — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Lena Sjordahl — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. Not Avail.
17. INFORMANT'S OWN SIGNATURE — C. C. Odden Jr. C — ADDRESS Ogden, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple / Injuries to body and head — INTERVAL BETWEEN ONSET AND DEATH: 2 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident /	Interstate Hwy #15	5½ miles S. of Dubois	Clark	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Aug. 16 1967 6:20 p.m.		Automobile Accident

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Morris H. Lawrence 583	Coroner 4	Dubois, Idaho	Aug. 22, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal (air)	8/17/67	Havre Cemetery	Havre, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 22, 1967	Morris H. Lawrence	Jack A. Wood, Jr.	396

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3527
Local Reg. No. 660
Reg. Dist. No.

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clark 170
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) North of Dubois
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Interstate 15 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orinda
d. STREET ADDRESS (If rural, give location) 14 Washington

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Theodore	Alton	Thomas Jr.	August	22	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married 1	March 15, 1943	24				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Serviceman 05	U.S. Air Force	Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Theodore A. Thomas	Iowa	Lorraine Carlotte Terry	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Viet Nam 8	Unknown	Information received over telephone	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Died en-route to hospital of injuries	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	substained in Auto-accident.	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident 1	Interstate #15 06	Rural 13 Dubois	Clark	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Aug. 22, 1967 6:00 a.m.		Auto Accident

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Morris H. Tavenner 583	Coroner	Dubois, Idaho	8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Removal 2	8/23/67	Fresno Cemetery	Fresno	California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-67	Morris H. Tavenner	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 12 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3528
Local Reg. No. 71
Reg. Dist. No. 210

BIRTH NO.

RECEIVED AUG 21 1967 Bureau of Vital Statistics

1-13

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
c. LENGTH OF STAY (in this place): 13 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Own home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): 651 Kalaspo

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ALMA	GENEVA	HUNTER	August 2 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
female	white	married 3	Jan. 9 1920	47		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Orofino, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John B. Strait	Missouri	Carrie Moos	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Florence Hunter	Orofino, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: min.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
8 2 67 1:30 P.M.		

22. *I hereby certify that I attended the deceased from* never, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Larry W. Sundvick 583 (Degree or title) Coroner	Pierce Idaho	8-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug. 5, 1967	Wells Bench	Orofino Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 15, 1967	June M. Powell	Lyle A. Gottmann	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 26 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3529
Local Reg. No. 72
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater 180 404
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino--rural
c. LENGTH OF STAY (in this place): hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fraser area farm 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 180
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print)
a. (First): PAUL
b. (Middle): M.
c. (Last): JACKSON

4. DATE OF DEATH (Month) (Day) (Year): August 16 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Dec. 23, 1904
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: agriculture
11. BIRTHPLACE (State or foreign country): Creston, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Jackson — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Christina Zinnicker — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-03-8850
17. INFORMANT'S OWN SIGNATURE: Josephine B. Dapp — ADDRESS: Orofino, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* never *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 2:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Larry Wunderlich 583 — (Degree or title): Coroner 4
23b. ADDRESS: Pierce, Idaho
23c. DATE SIGNED: Aug. 26 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 19 1967
24c. NAME OF CEMETERY OR CREMATORY: L-C Memorial Gardens
24d. LOCATION (City, town, or county) (State): Lewiston Idaho

DATE REC'D BY LOCAL REG.: August 28, 1967
REGISTRAR'S SIGNATURE: June M. Powell
25. EMBALMER: Lyle A. Strattmann
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3530
Local Reg. No. 73
Reg. Dist. No. 210

BIRTH NO.

RECEIVED AUG 29 1967 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY Clearwater 180 1-09
b. CITY OR TOWN Orofino
LENGTH OF STAY (in this place) 9 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Lumberman Hotel Cabins

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 180 b. COUNTY Clearwater
c. CITY OR TOWN Orofino
d. STREET ADDRESS (If rural, give location) Lumberman Hotel

3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) S. c. (Last) MULLAN

4. DATE OF DEATH (Month) (Day) (Year) Aug. 23 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) unknown

8. DATE OF BIRTH Jan. 20, 1886

9. AGE (In years last birthday) 81 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodsworker 17

10b. KIND OF BUSINESS OR INDUSTRY Timber

11. BIRTHPLACE (State or foreign country) Bemidji, Minnesota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME unknown BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME unknown BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 517-07-0617

17. INFORMANT'S OWN SIGNATURE Josephine K. Duff ADDRESS Orofino, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* never, 19, *to* , 19, *that I last saw the deceased alive on* , 19, *and that death occurred at* 3:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Fay W Sundvick 583 (Degree or title) Coroner

23b. ADDRESS Pierce, Idaho

23c. DATE SIGNED Aug. 26 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Aug. 25 1967

24c. NAME OF CEMETERY OR CREMATORY Riverside

24d. LOCATION (City, town, or county) Orofino (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 28, 1967

REGISTRAR'S SIGNATURE June M. Powell

25. EMBALMER Ivy C. Gilbertson LICENSE NO. 476

FIRM NAME: Gilbert's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3531
Local Reg. No. 74
Reg. Dist. No. 210

BIRTH NO.

RECEIVED SEP 1 1967 Vital Statistics Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (in this place) few min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) US Highway # 12 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Spokane 5-05
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 543 Eculid

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
LARRY	DALE	MONTANEY	Aug.	30	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	June 30, 1942	25				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Apprentice Iron Worker	Constr.	Spokane, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Leslie Montaney 11	Riverside, Wash.	Olive Cloe	Malta, Mont.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes I-1961-419628	561-56-2083	X Leslie D. Montaney	Spokane, Wn.

8164

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed chest & Internal Injuries — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto Accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 170	(COUNTY)	(STATE)
Accident /	US Highway # 12 00	Orofino 13	Clearwater	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Aug	30	'67	10:00 p.m. 2		Auto collision

22. *I hereby certify that I attended the deceased from* never 19__ *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 10:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Larry W Sunderlich 583	Coroner 4	Pierce, Idaho	Aug. 31 '67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Removal 3	Aug. 31 '67	Ball and Dodd FH	Spokane	Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 31, 1967	June M. Powell	Lyle L. Gilbertson	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 25 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 3 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

DEC 11 1972

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

JAN 23 1975

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3532
Local Reg. No. 57
Reg. Dist. No. 380 391

BIRTH NO. 67-6780

RECEIVED AUG 31 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN Mtn Home AFB
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 67 Tac Hosp, Mt Home AFB ID

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 200
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mtn Home
d. STREET ADDRESS (If rural, give location) Rt 1, Box 720-D

3. NAME OF DECEASED (Type or Print) a. (First) CARMEN b. (Middle) MARIA 077 c. (Last) RIVERO

4. DATE OF DEATH (Month) July (Day) 27 (Year) 1967

5. SEX Female

6. COLOR OR RACE CAU

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH 27 July 1967

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. 39

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Jose R, Rivere BIRTHPLACE Queens, New York

14. MOTHER'S MAIDEN NAME Carol A, White BIRTHPLACE Benson, Minn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Official Medical Records ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7620

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral pneumothorax — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 27 Jul, 19 67, to 27 Jul, 19 67, *that I last saw the deceased alive on* 27 Jul, 19 67, *and that death occurred at* 0615 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Barry S Russman (Degree or title) BARRY S. RUSSMAN, CAPT, USAF, MC 585-MD

23b. ADDRESS Mtn Home AFB, Idaho

23c. DATE SIGNED 27 July 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 8 - 1 -67

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) Benson, Minnesota

DATE REC'D BY LOCAL REG. Aug 29 1967

REGISTRAR'S SIGNATURE

25. EMBALMER Conway Funeral

LICENSE NO. E478

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED AUG 18 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3533
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) King Hill (rural) | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCoy-Jones Ranch 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 200 b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) King Hill (rural)
d. STREET ADDRESS (If rural, give location) McCoy-Jones Ranch

3. NAME OF DECEASED (Type or Print): a. (First) EDITH b. (Middle) DORA c. (Last) STUHLBERG

4. DATE OF DEATH (Month) (Day) (Year): Aug. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Dec. 7, 1922	44				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	at home	Prosser, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harold S. Hurd	Nebraska	Dora Robinson	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	none	X Oscar Stuhlberg	King Hill, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Rheumatic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 36 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan 4, 1967, *to* Aug 7, 1967, *that I last saw the deceased alive on* April 3, 1967, *and that death occurred at* 7:15a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wendell Ruben 45 MD	Box 70 Glenns Ferry Ida	Aug 9, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 10, 1967	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 9-67	Mary McCowan	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3534
Local Reg. No. 68
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED AUG 31 1967 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
d. STREET ADDRESS (If rural, give location) 520 East 2nd S.

3. NAME OF DECEASED (Type or Print) a. (First) JESSIE b. (Middle) LUCILLE c. (Last) AMY

4. DATE OF DEATH (Month) (Day) (Year) August 29, 1967

5. SEX Female
6. COLOR OR RACE Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 22, 1899
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OO
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boulder, Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William A. Tipps — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Cleo Maude Logan — BIRTHPLACE Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 524-10-6085 A
17. INFORMANT'S OWN SIGNATURE Joanne Wright ADDRESS Las Vegas, Nevada

4221

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Insufficiency

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Arteriosclerosis.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Guy W. Wallace (Degree or title) M.D.
23b. ADDRESS Mountain Home, Idaho
23c. DATE SIGNED 8/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/14/67
24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery
24d. LOCATION (City, town, or county) (State) Mountain Home, Idaho

DATE REC'D BY LOCAL REG. Aug 30 1967
REGISTRAR'S SIGNATURE
25. EMBALMER Arthur Smith
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3535
Local Reg. No. 59
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED AUG 31 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Owhyee-Elmore 200 000
b. CITY OR TOWN Grandview-Mtn Home AFB (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 67 Tac Hosp, Mtn Home AFB ID

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 320 b. COUNTY Owhyee
c. CITY OR TOWN Grandview
d. STREET ADDRESS (If rural, give location) Box 334

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	JACK	LEE 077	COLLINS	Aug	13	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married 2	May 19, 1928	38				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
USAF - MSgt 05	USAF	West Virginia	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John P. Collins		Orpha M. Hess	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Jan 22, 1946	232-36-3653	Official Medical Records	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 13, 1967, *to* Aug 13, 1967, *that I last saw the deceased alive on* Aug 13, 1967, *and that death occurred at* 2100 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Barry S. Russman BARRY S. RUSSMAN, CAPT, USAF, MC 585 MD	Mtn Home AFB, Idaho	14 Aug 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/17/67	Riverside Cemetery	Grand View, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 29 1967	[signature]	Conway Grant	E-478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3536
Local Reg. No. 61
Reg. Dist. No. 380 391

RECEIVED AUG 31 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 200
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 380 So. 3rd East

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): FRANKLIN
c. (Last): GISLER

4. DATE OF DEATH (Month) (Day) (Year): August 24, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 23, 1876
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Maintenance 06
10b. KIND OF BUSINESS OR INDUSTRY: Canal Co.
11. BIRTHPLACE (State or foreign country): Wilshire, Ohio
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael Gisler
BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Susan Baltzall
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Spanish American 4200
16. SOCIAL SECURITY NO.: 519-01-3497
17. INFORMANT'S OWN SIGNATURE: Thomas M Gisler
ADDRESS: Mt. Home

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 8/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/26/67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Aug 29 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Ward Humphrey
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 6 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 29 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 3 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3537
Local Reg. No. 60
Reg. Dist. No. 380 391

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 31 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 370
b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bruneau
d. STREET ADDRESS (If rural, give location) Bruneau

3. NAME OF DECEASED (Type or Print)
a. (First) ERROL
b. (Middle) FLETCHER 080
c. (Last) BLACK

4. DATE OF DEATH (Month) (Day) (Year) August 24, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 5, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Stockman
10b. KIND OF BUSINESS OR INDUSTRY: Livestock
11. BIRTHPLACE (State or foreign country): Leveridge Ferry, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Black 04 — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Alice Loveridge — BIRTHPLACE: Nevada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War 1 3
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: John P Black — ADDRESS: Grand View

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5272

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic obstructive lung disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on* Aug 24, 1967, *and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 718 Troy W. Walker M.D.
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 8/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/28/67
24c. NAME OF CEMETERY OR CREMATORY: Bruneau Cemetery
24d. LOCATION (City, town, or county) (State): Bruneau, Idaho

DATE REC'D BY LOCAL REG.: Aug 29 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Arthur Smith
LICENSE NO.: E-403
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3538
Local Reg. No. 62
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
d. STREET ADDRESS (If rural, give location): Box 111

3. NAME OF DECEASED (Type or Print)
a. (First): MELVIN
b. (Middle): 080
c. (Last): YAZZIE

4. DATE OF DEATH: August 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	Indian	Never Married	Feb. 3, 1964	3				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ned R. Yazzie — BIRTHPLACE: New Mexico
14. MOTHER'S MAIDEN NAME: Emma H. Herrera — BIRTHPLACE: New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Ned R. Yazzie — ADDRESS: Glenns Ferry

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 5711 Toxic Colitis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 7/8 Dwight W. Waller MD
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 8/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/30/67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Sept 18 1966
REGISTRAR'S SIGNATURE: [illegible] Nicholson
25. EMBALMER: Arthur Smith
LICENSE NO.: E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3539
Local Reg. No. 8
Reg. Dist. No. 540

BIRTH NO. 67-7777

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Franklin 210 000
b. CITY OR TOWN: Preston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 210
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Janet		Ward	July 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Never Married	July 27, 1967				12	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child 02	None	Preston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Gordon Ward	Afton, Wyo.	Ann Seeley	Preston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		C. Gordon Ward	Preston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bronchitis b/m — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Parenchymal Nephritis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-17, 1967, *to* 7-27, 1967, *that I last saw the deceased alive on* 7-27, 1967, *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. R. Cutler M.D.	Preston Idaho	7-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	July 28, 1967	Preston Cemetery	Preston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7-28-67	Eppie W. Brouwer	O. Sherwin Webb	316

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3540
Local Reg. No. 14
Reg. Dist. No. 540

Certificate of Death

RECEIVED
SEP 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 210 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Preston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Lakes, near Preston Ida. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1413 Monte Vista

3. NAME OF DECEASED (Type or Print)
a. (First): Danna
b. (Middle): Edward
c. (Last): Price

4. DATE OF DEATH (Month) (Day) (Year): Aug. 5, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: July 27, 1958
9. AGE (In years last birthday): 9 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: XXXX
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clair Price — BIRTHPLACE: Smithfield, Utah
14. MOTHER'S MAIDEN NAME: Alice Anderson — BIRTHPLACE: Burley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: 9298
17. INFORMANT'S OWN SIGNATURE: Clair Price — ADDRESS: Pocatello Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Twin Lakes 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Preston 13 210 Franklin Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 5 67 7 p.m. 2
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ 2
21f. HOW DID INJURY OCCUR?: Swimming in Reservoir

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 7 p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Clair J. Cutler 119 Mp
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 8-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Aug. 8, 67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: 8-8-1967
REGISTRAR'S SIGNATURE: Eppie W. Brower
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3541
Local Reg. No. 9
Reg. Dist. No. 240

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Franklin 210
b. CITY OR TOWN Preston
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 28 South 1st West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 210
b. COUNTY Franklin
c. CITY OR TOWN Preston
d. STREET ADDRESS (If rural, give location) 28 South 1st West

3. NAME OF DECEASED (Type or Print) a. (First) Carlos b. (Middle) Daniel c. (Last) Glover

4. DATE OF DEATH (Month) (Day) (Year) Aug. 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 31, 1884
9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Stock Farm
11. BIRTHPLACE (State or foreign country) Lewiston, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William F. Glover BIRTHPLACE San Francisco, Cal.
14. MOTHER'S MAIDEN NAME Sarah Jane Barnes BIRTHPLACE Nauvoo, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 38 5980
17. INFORMANT'S OWN SIGNATURE Jennie Glover ADDRESS Preston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5271

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 5 Yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Emphysema
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 55, *to* Aug. 7, 1967, *that I last saw the deceased alive on* Aug. 6, 1967, *and that death occurred at* 3 a m., *from the causes and on the date stated above.*

23a. SIGNATURE Leo R. Hawkes 214 (Degree or title) M.D.
23b. ADDRESS Preston, Idaho
23c. DATE SIGNED 8/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Lewiston Cemetery
24d. LOCATION (City, town, or county) Lewiston, Utah (State)

DATE REC'D BY LOCAL REG. 8-10-67
REGISTRAR'S SIGNATURE Eppie W. Brower
25. EMBALMER O. Sherwin Webb
LICENSE NO. 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 2 5 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3542
Local Reg. No. 12
Reg. Dist. No. 3 4 6

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Franklin 210 2-03
b. CITY OR TOWN: Dayton
LENGTH OF STAY (in this place): 3 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dayton 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 210
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print): a. (First) Priscilla b. (Middle) Alder c. (Last) Johnson

4. DATE OF DEATH: (Month) (Day) (Year) August 11, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: February 20, 1891
9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Preston, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Wm Alfred Alder
BIRTHPLACE: Preston, Idaho
14. MOTHER'S MAIDEN NAME: Sarah Crestina Jensen
BIRTHPLACE: Preston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 12 6373
17. INFORMANT'S OWN SIGNATURE: Ardell D Henderson
ADDRESS: Dayton, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — 3 yrs

DUE TO (c) Asthenia senilis — 16 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 6, 1967, *to* Aug 11, 1967, *that I last saw the deceased alive on* Aug 6, 1967, *and that death occurred at* 1 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: O. R. Cutler 122 (Degree or title) MD
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 8-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery
24d. LOCATION (City, town, or county) (State): Preston, Idaho

DATE REC'D BY LOCAL REG.: 8-15-67
REGISTRAR'S SIGNATURE: Eppie W. Brauer
25. EMBALMER: O. Sherwin Webb
LICENSE NO.: 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3543
Local Reg. No. 13
Reg. Dist. No. 540

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 29 1967
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Franklin 210 1-36	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho 210 b. COUNTY: Franklin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston c. LENGTH OF STAY (in this place): 36 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 168 E 2nd S 000	d. STREET ADDRESS (If rural, give location): 168 E 2nd S

3. NAME OF DECEASED (Type or Print)	a. (First): James	b. (Middle): Richard	c. (Last): Rawlings	4. DATE OF DEATH (Month) (Day) (Year): Aug 11, 1967
5. SEX: male	6. COLOR OR RACE: white	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: Jan 10, 1886	9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04		10b. KIND OF BUSINESS OR INDUSTRY: Agriculture	11. BIRTHPLACE (State or foreign country): Fairview, Idaho	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Ephraim J. Rawlings		BIRTHPLACE: England	14. MOTHER'S MAIDEN NAME: Eliza Jane Shurtz	BIRTHPLACE: East Mill Creek, Ut.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519 12 2209	17. INFORMANT'S OWN SIGNATURE: Atheron Rawlings	ADDRESS: Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASVD — 20 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1965, *to* Aug 11, 1967, *that I last saw the deceased alive on* Aug 1, 1967, *and that death occurred at* 1 p m, *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 119 MV	23b. ADDRESS: Preston Idaho	23c. DATE SIGNED: 8-15-67	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Aug 14, 1967	24c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery	24d. LOCATION (City, town, or county) (State): Preston, Idaho
DATE REC'D BY LOCAL REG.: 8-15-67	REGISTRAR'S SIGNATURE: Eppie W. Brower	25. EMBALMER: O. Sherwin Webb	LICENSE NO.: 316

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 14 1967
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3544
Local Reg. No. 13
Reg. Dist. No. 1-40

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 210 1-62
b. CITY OR TOWN Preston
LENGTH OF STAY (in this place) 62 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial Hospital 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 210
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) South of City

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Coral	Peterson	Hollingsworth	Aug. 20 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	March 3, 1905	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own home	Preston, Idaho	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Soren Peterson	Morgan, Utah	Louise Spongberg	Franklin, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			E. M. Hollingsworth	Preston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 10, 1967, *to* Aug 26, 1967, *that I last saw the deceased alive on* Aug 20, 1967, *and that death occurred at* 7:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. R. Cutler	MD	Preston Idaho	8-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 23, 1967	Preston	Preston Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-23-67	Effie W. Brewer	O. Sherwin Webb	316

Federal Security Agency
United States Public Health Service
Form DH-69021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3545
Local Reg. No. 16
Reg. Dist. No. 340

RECEIVED
SEP 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 210 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 210 b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) W 8th S

3. NAME OF DECEASED (Type or Print) a. (First) Virginia Mary b. (Middle) 081 c. (Last) Dorigatti

4. DATE OF DEATH (Month) (Day) (Year) Aug. 21 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 21, 1883
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Berz, Tyrol, Austria
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Corazza BIRTHPLACE
14. MOTHER'S MAIDEN NAME Mary Dorighi BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs Mary Dorigatti ADDRESS Preston, Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cholecystitis with Scholelithiasis
Diabetes mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Osteo-arthritis
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 10, 1967 *, to* Aug 21, *, 19* 67 *, that I last saw the deceased alive on* Aug. 21 *, 1967 , and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Leo R. Hawkes (Degree or title) M.D.
23b. ADDRESS Preston, Idaho
23c. DATE SIGNED 8/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 25, 1967
24c. NAME OF CEMETERY OR CREMATORY St Joseph Cemetery
24d. LOCATION (City, town, or county) (State) Rock Springs, Wyoming

DATE REC'D BY LOCAL REG. 8-25-1967
REGISTRAR'S SIGNATURE Eppie M. Brewer
25. EMBALMER Douglas S. Webb
LICENSE NO. 488

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3546
Local Reg. No. 23
Reg. Dist. No. 651

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220 — SEP 6 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print): a. (First) ROBERT — b. (Middle) LOVE — c. (Last) GUNTER

4. DATE OF DEATH (Month) (Day) (Year): July 20, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 28 May 1892

9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 60

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Marsh Valley, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Alexander Gunter — BIRTHPLACE: No. Carolina

14. MOTHER'S MAIDEN NAME: Sarah Jane York — BIRTHPLACE: South Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI 3

16. SOCIAL SECURITY NO.: 532-05-2217A

17. INFORMANT'S OWN SIGNATURE: + Elara B Gunter — ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 6 Days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Hypertensive Cardio-vascular-renal disease — 1 year

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Uremic coma

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* May, 1960, *to* 20 July, 1967, *that I last saw the deceased alive on* 20 July, 1967, *and that death occurred at* 2:10 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 352 W. A. Melchen, MD — **23b. ADDRESS**: Ashton, Idaho — **23c. DATE SIGNED**: 1 Aug. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 22 July 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Pineview Cemetery — **24d. LOCATION** (City, town, or county) (State): Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.: 2 Aug 67 — **REGISTRAR'S SIGNATURE**: M Hansen — **25. EMBALMER**: Robert Q. Bean — **LICENSE NO.**: E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3547
Local Reg. No. 43
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 020 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 320 b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): None Given

3. NAME OF DECEASED (Type or Print): a. (First) ROBERT b. (Middle) 083 c. (Last) GUNTER

4. DATE OF DEATH (Month) (Day) (Year): August 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	21 July 1903	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Barkers Creek, North Carolina	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Gunter	North Carolina	Elmira D. Gibson	North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No ------	518-32-4719	Leah Gunter	Ashton, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4341

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Anemia, microcytic — 1 year
Infected sunburn, face — 1 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 6, 1967, *to* August 3, 1967, *that I last saw the deceased alive on* August 3, 1967 *and that death occurred at* 10:30P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
	298	Ashton, Idaho	8-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	7 August 67	Pineview Cemetery	Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
20 August 67	Mel Hansen	Robert O. Bean	E-456

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bean Funeral Home

DUTIES: MAR 29 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK int or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3548
Local Reg. No. 22
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 220
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Teton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) HOLLY b. (Middle) JOYCE 083 c. (Last) NELSON

4. DATE OF DEATH (Month) (Day) (Year): August 4, 1967

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: April 6, 1967

9. AGE (In years last birthday): IF UNDER 1 YEAR Months: 3 Days: 28; IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ashton, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wayne Nelson BIRTHPLACE: Canyon Creek, Idaho

14. MOTHER'S MAIDEN NAME: Joyce Furniss BIRTHPLACE: Driggs, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Wayne Nelson ADDRESS: Teton, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Congenital Heart disease 7545 — INTERVAL BETWEEN ONSET AND DEATH: 4 mos.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6 April, 1967, *to* 4 Aug., 1967, *that I last saw the deceased alive on* 28 July, 1967, *and that death occurred at* 6:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 352 W. A. Nelson M.D. **23b. ADDRESS**: Ashton, Idaho **23c. DATE SIGNED**: 6 Aug. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial **24b. DATE**: 7 August 67 **24c. NAME OF CEMETERY OR CREMATORY**: Teton-Newdale Cemetery **24d. LOCATION** (City, town, or county) (State): Sugar City, Madison, Idaho

DATE REC'D BY LOCAL REG.: 7 August 67 REGISTRAR'S SIGNATURE: M. L. Hansen **25. EMBALMER**: M. L. Hansen LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hansen Memorial Chapel

DUTIES: D-67-3623 AUG 25 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 5 1967 Bureau of Vital Statistics

State File No. 3549
Local Reg. No. 45
Reg. Dist. No. 651

Certificate of Death
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton | LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05 b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Atherton
d. STREET ADDRESS (If rural, give location): 76 Almendral St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	THOMAS	FRANCIS	KEARNS, JR.	August 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	3 July 1921	46		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Owner-Manager Metro 22	Employment Agency	Salt Lake City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas F. Kearns, Sr.	Unknown	Kathryn Whitney	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. II 4		Jacqueline E. Kearns	Atherton, California

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	BRONCHOPNEUMONIA, EARLY, GENERALIZED	1-2 DAYS
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	ALCOHOLISM, ACUTE AND CHRONIC BY CLINICAL HISTORY	YEARS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
NONE		ASHTON	FREMONT	IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
342 HAZEL L. McCAFFEY, M.D. PATHOLOGIST	2525 South BOULEVARD, IDAHO FALLS	8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal for Burial	8/8/67	Mt. Calvary Cemetery	Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
27 August	M. L. Hansen	Robert Bean	E-456

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Bean Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 6 1967

AUG 26 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 21 1985

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3550
Local Reg. No. 44
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place): 008
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): None Given

3. NAME OF DECEASED (Type or Print): a. (First) MAE b. (Middle) ROSETTE 083 c. (Last) BOWERSOX MOORE

4. DATE OF DEATH (Month) (Day) (Year): August 12, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 7 Sept. 1888

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Lock Springs, Mo.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Bowersox — BIRTHPLACE: Pennsylvania

14. MOTHER'S MAIDEN NAME: Brunette Brookshier — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: * Thomas L. Rice — ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cholecystitis, chronic non functioning gallbladder — 6 mo.

19a. DATE OF OPERATION: 8-7-67

19b. MAJOR FINDINGS OF OPERATION: Non functioning gallbladder Cholelithiasis

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): /

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-7- *, 1967, to* 8-12- *, 1967, that I last saw the deceased alive on* 8-12- *1967, and that death occurred at* 9:42 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 298

23b. ADDRESS: Ashton, Idaho

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 16 August 67

24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery

24d. LOCATION (City, town, or county) (State): Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.: 25 August

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: X Robert O. Bean — LICENSE NO.: E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended August 1, 1969

Certificate of Death
STATE OF IDAHO

State File No. 3551
Local Reg. No. 46
Reg. Dist. No. 651

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Fremont	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Jefferson
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Island Park c. LENGTH OF STAY (In this place): Min.	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mile Post #1-7.7	d. STREET ADDRESS (If rural, give location): 167 So. 1st West St.

3. NAME OF DECEASED (Type or Print)	a. (First): Howard	b. (Middle):	c. (Last): Humphrey	4. DATE OF DEATH	(Month) (Day) (Year): August 15, 1967	
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: Jan 15, 1894	9. AGE (In years last birthday): 73	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook	10b. KIND OF BUSINESS OR INDUSTRY: Restaurant		11. BIRTHPLACE (State or foreign country): Millville, Utah		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Lorenzo Humphrey	BIRTHPLACE: Iowa		14. MOTHER'S MAIDEN NAME: Annis Spackman		BIRTHPLACE: England	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.		17. INFORMANT'S OWN SIGNATURE: Edna Humphrey		ADDRESS: Rigby, Idaho	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Crushed chest — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes [XX] No [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.): Street	21c. (CITY, TOWN, OR TOWNSHIP): Island Park	(COUNTY): Fremont	(STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): August 15, 1967-8:30PM	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR? Lost control of vehicle		

DOA

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul Romrell, Coroner	23b. ADDRESS: St. Anthony, Idaho	23c. DATE SIGNED: 8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Aug. 18, 1967	24c. NAME OF CEMETERY OR CREMATORY: Little Butte	24d. LOCATION (City, town, or county) (State): Annis, Jefferson, Idaho

DATE REC'D BY LOCAL REG.: 31 August 67	REGISTRAR'S SIGNATURE: M. D. Hansen	25. EMBALMER: Bruce A. Eckersell	LICENSE NO.: E-404

Federal Security Agency
United States Public Health Service FORM DH--63021

FIRM NAME: Eckersell Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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.....

A F F I D A V I T

STATE OF IDAHO)
ss
County of Jefferson)

Bruce Eckersell, being first duly sworn on his oath, deposes and says:

That he is a resident of the City of Rigby, County of Jefferson, State of Idaho; that he is a mortician and a partner in Eckersell Funeral Home at Rigby, Jefferson County, Idaho; that according to the records of said funeral home and according to his recollection, on August 15, 1967, the body of Howard Humphrey was received at the Eckersell Funeral Home, who, according to the records and statements made at the time, was killed in an accident at Island Park, Fremont County, Idaho, on the highway on August 15, 1967, said date constituting both the date of his death and the date of the accident.

Bruce A. Eckersell

Subscribed and sworn to before me this 22nd day of July, , 1969.

James A. Rice
Notary Public in and for the State of Idaho, Residing at Rigby, Idaho
My Commission Expires: 10-24-72

A F F I D A V I T

STATE OF IDAHO)
ss
County of Jefferson)

Bruce Eckersell, being first duly sworn on his oath, deposes and says:

That he is a resident of the City of Rigby, County of Jefferson, State of Idaho; that he is a mortician and a partner in Eckersell Funeral Home at Rigby, Jefferson County, Idaho; that according to the records of said funeral home and according to his recollection, on August 15, 1967, the body of Howard Humphrey was received at the Eckersell Funeral Home, who, according to the records and statements made at the time, was killed in an accident at Island Park, Fremont County, Idaho, on the highway on August 15, 1967, said date constituting both the date of his death and the date of the accident.

Bruce A. Eckersell

Subscribed and sworn to before me this 2nd day of June, 1969.

Notary Public in and for the State of Idaho, Residing at Rigby, Idaho
My Commission Expires: [illegible]

JAMES L. RIRIE
NOTARY PUBLIC
STATE OF IDAHO

A F F I D A V I T

STATE OF IDAHO)
ss
County of Jefferson)

DONNA JENSEN, being first duly sworn on her oath, deposes and says:

That she is now, and was on the 15th day of August, 1967, the daughter of Howard Humphrey, now deceased; that on said 15th day of August, 1967, an accident occurred in Island Park, Fremont County, State of Idaho, which took the life of her father, Howard Humphrey; that the date of the accident and the date of the death of Howard Humphrey were one and the same, to-wit: August 15, 1967.

Donna Jensen

Subscribed and sworn to before me this 7th day of July, 1969.

Notary Public in and for the State of Idaho, Residing at Rigby, Idaho
My Commission Expires: 10-24-72

A F F I D A V I T

STATE OF IDAHO)
) ss
County of Jefferson)

DONNA JENSEN, being first duly sworn on her oath,

deposes and says:

That she is now, and was on the 15th day of August, 1967, the daughter of Howard Humphrey, now deceased; that on said 15th day of August, 1967, an accident occurred in Island Park, Fremont County, State of Idaho, which took the life of her father, Howard Humphrey; that the date of the accident and the date of the death of Howard Humphrey were one and the same, to-wit: August 15, 1967.

[redacted]

Subscribed and sworn to before me this [redacted] day of [redacted], 1967.

[redacted]
Notary Public in and for the State of Idaho. Residing at Rigby, Idaho
My Commission Expires: 8-24-72

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3551
Local Reg. No. 24
Reg. Dist. No. 651

RECEIVED SEP 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Island Park
LENGTH OF STAY (in this place): min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mile Post #1-7.7 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 260
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 167 So. 1st West St.

3. NAME OF DECEASED (Type or Print): a. (First) HOWARD b. (Middle) c. (Last) HUMPHREY

4. DATE OF DEATH (Month) (Day) (Year): Aug. 15, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 15, 1894

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook 01

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Millville, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lorenzo Humphrey
BIRTHPLACE: IOWA

14. MOTHER'S MAIDEN NAME: Annis Spackman
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 8254

17. INFORMANT'S OWN SIGNATURE: Edna Humphrey ADDRESS: Rigby, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Crushed chest — INTERVAL BETWEEN ONSET AND DEATH: 10 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street 04

21c. (CITY, TOWN, OR TOWNSHIP) 260 **(COUNTY)** **(STATE)**: 13 Island Park Fremont Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 20 67 8:30 p.m.

21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?: lost control of vehicle

22. *I hereby certify that I attended the deceased from* DOA, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul Lowell 583 (Degree or title): coroner

23b. ADDRESS: St. Anthony, Ida.

23c. DATE SIGNED: 8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 18, 1967

24c. NAME OF CEMETERY OR CREMATORY: Little Butte

24d. LOCATION (City, town, or county) (State): Annis Jefferson Idaho

DATE REC'D BY LOCAL REG.: 31 August 67

REGISTRAR'S SIGNATURE: M. L. Hansen

25. EMBALMER: Bruce A. Eckersell Bruce A. Eckersell

LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 26 1967

SEP 27 1967

OCT 6 1967

AUG 6 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3552
Local Reg. No. 33
Reg. Dist. No. 651

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN: Ashton
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana 27
b. COUNTY: 535 Gallatin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): West Yellowstone
d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print)
a. (First): NINA
b. (Middle): O. 320
c. (Last): CHEATLEY

4. DATE OF DEATH: August 18, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 31 July 1905
9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Boulder, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William G. Whetstone
BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Nellie Josephine Berkins
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: 571-01-9912
17. INFORMANT'S OWN SIGNATURE: Eugene W. Cheatley
ADDRESS: West Yellowstone, Mont.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Ovarian Carcinoma
INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 1965 *to* 8-18, 1967, *that I last saw the deceased alive on* 8-12, 1967, *and that death occurred at* 109 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature]
(Degree or title): 298
23b. ADDRESS: Ashton, Idaho
23c. DATE SIGNED: 9-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 18 Aug. 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Hills Cemetery
24d. LOCATION (City, town, or county) (State): Bozeman Montana

DATE REC'D BY LOCAL REG.: 10 Sept 67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Harvard Nelson
LICENSE NO.: 167
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 12 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3553
Local Reg. No. 49
Reg. Dist. No. 651

Certificate of Death

RECEIVED
SEP 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello Spouse: Eva Irene Stephenson, Parkinson
d. STREET ADDRESS (If rural, give location): 118 So. 13th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Thomas
b. (Middle): Dean 083
c. (Last): Parkinson

4. DATE OF DEATH (Month) (Day) (Year): Aug 19 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 22, 1903
9. AGE (In years last birthday): 63 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ticket Agent 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Portage, Box Elder, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Thomas Parkinson; BIRTHPLACE: Portage, Utah
14. MOTHER'S MAIDEN NAME: Annie Leona John; BIRTHPLACE: Portage, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 712-05-1311
17. INFORMANT'S OWN SIGNATURE: Sana S. Benson; ADDRESS: 118 S. 13 - Pocatello, Idh.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): —
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 19 Aug, 1967, *to* 19 Aug, 1967, *that I last saw the deceased alive on* 19 Aug, 1967, *and that death occurred at* 6:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. A. Melcher 353 (Degree or title) M.D.
23b. ADDRESS: Ashton, Idaho
23c. DATE SIGNED: 19 Aug. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 19, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mt N. View Cemetery
24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: 2 Sept 67
REGISTRAR'S SIGNATURE: M. L. Hansen
25. EMBALMER: Raiford H. Benson — LICENSE NO.: E-351

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: BENSON FUNERAL HOME, Malad, Idh.

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 25 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 26 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3554
Local Reg. No. 47
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 220 SEP 5 1967 3-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Island Park
c. LENGTH OF STAY in this place: 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Summer Cabin West of Ponds Lodge

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 980 June Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Alwena; b. (Middle) M. 000; c. (Last) STILES

4. DATE OF DEATH (Month) (Day) (Year): August 20, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: December 17, 1879

9. AGE (In years last birthday): 88 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Johann Gerken — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Louise V. Vollstead — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Not Avail.

17. INFORMANT'S OWN SIGNATURE: Idaho Falls, Idaho — ADDRESS: 980 JUNE AVE

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19 67, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul Cornell 583 — (Degree or title): Coroner 4

23b. ADDRESS: St. Anthony, Idaho

23c. DATE SIGNED: 8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/24/67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: 31 Aug 67

REGISTRAR'S SIGNATURE: M L Hansen

25. EMBALMER: Jack A. Wood, Jr. — LICENSE NO.: 396

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to -

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3555
Local Reg. No. 48
Reg. Dist. No. 651

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Fremont 028 SEP 5 1967 000

b. CITY OR TOWN: Teton City,

c. LENGTH OF STAY: Bureau of Vital Statistics

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 117 North 1st East 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 228

b. COUNTY: Fremont

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Teton City,

d. STREET ADDRESS (If rural, give location): 117 North 1st East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAMES	CLARENCE	SIDDOWAY	August 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married 3	April 22, 1889	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer and Sheepman	Self Employed	Teton City, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Wm. Siddoway 04	Salt Lake City, Utah	Ruth Briggs	Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-44-1444	Newton B Siddoway	Teton City, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Diabetes Mellitus

DUE TO (c) Obesity

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

2608

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March, 1965, *to* Aug 24, 1967, *that I last saw the deceased alive on* Aug 24, 1967, *and that death occurred at* 11 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ref G. Maley 317 MD	Rexburg Idaho	8-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	28 August 67	Teton-Newdale Cemetery	Sugar City, RFD, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
31 Aug 67	M L Hansen	M L Hansen	E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3556
Local Reg. No. 51
Reg. Dist. No. 650

BIRTH NO.

RECEIVED SEP 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Fremont 221 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 22
b. COUNTY Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) RFD#1

3. NAME OF DECEASED (Type or Print) a. (First) ROSA b. (Middle) B. 082 c. (Last) SMITH BIRCH

4. DATE OF DEATH (Month) (Day) (Year) August 29, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 18, 1889
9. AGE (In years last birthday) 78 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) St. Anthony RFD#1 (Wilford) Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Fredrick T. Smith BIRTHPLACE St. Thomas, Nevada
14. MOTHER'S MAIDEN NAME Sarah Ann Higbee BIRTHPLACE Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Lyle M. Birch ADDRESS Ashton, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, generalized — 5 Years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 19 60, *to* August 29 19 67, *that I last saw the deceased alive on* August 29 19 67, *and that death occurred at* 2:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert R. Klamm, M.D. (Degree or title) 284
23b. ADDRESS St. Anthony, Idaho
23c. DATE SIGNED 9/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1 Sept 67
24c. NAME OF CEMETERY OR CREMATORY Wilford Cemetery
24d. LOCATION (City, town, or county) (State) St. Anthony (RFD#1) Idaho

DATE REC'D BY LOCAL REG. 9-11-67
REGISTRAR'S SIGNATURE M. L. Hansen
25. EMBALMER M. L. Hansen
LICENSE NO. E-354

FIRM NAME: Hansen Memorial

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 2 3 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3557
Local Reg. No. 6
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 23/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) 33 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Walter Knox Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 23/ b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 217 E. 2nd.

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) F. 085 c. (Last) Block

4. DATE OF DEATH (Month) (Day) (Year) August 2, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 28, 1883
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY own Farm
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Block — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Emilie Ladwig — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — —
16. SOCIAL SECURITY NO. 505-40-4962
17. INFORMANT'S OWN SIGNATURE Emily Naher Rt 2 ADDRESS Emmett, Id.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pleural Effusion — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastasis from bowel tumor — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-6, 19 55, *to* 8-2, 19 67, *that I last saw the deceased alive on* 8-2, 19 67, *and that death occurred at* 7:30 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Thomas E. Halverson 24/ (Degree or title) MD
23b. ADDRESS Emmett, Idaho
23c. DATE SIGNED 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY Emmett Cemetery
24d. LOCATION (City, town, or county) Emmett (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 9, 1967
REGISTRAR'S SIGNATURE Jean A Beatty
25. EMBALMER Gifford L. Shaffer
LICENSE NO. E-344
FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUL 1 2 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3558
Local Reg. No. 9
Reg. Dist. No. 340 341

BIRTH NO. 67-7801

RECEIVED AUG 15 1967 Vital Statistics Bureau

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 23
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 2 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: 555 San Juan
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Vandalden
d. STREET ADDRESS (If rural, give location): General Delivery

3. NAME OF DECEASED (Type or Print): a. (First) Jeff; b. (Middle) 085; c. (Last) Stout

4. DATE OF DEATH (Month) (Day) (Year): August 2, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: August 2, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours: 2 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Emmett, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Floyd B. Stout — BIRTHPLACE: Powells Valley, Okla.

14. MOTHER'S MAIDEN NAME: Opal Inez Williams — BIRTHPLACE: Durant, Okla.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X Floyd Stout — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7593

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity and Congenital Anomaly — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-2, 19 67, *to* 8-2, 19 67, *that I last saw the deceased alive on* 8-2, 19 67, *and that death occurred at* 3:05 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harmon E. Holverson MD 241

23b. ADDRESS: Emmett, Idaho

23c. DATE SIGNED: 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Aug. 4, 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Aug 9, 1967

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty — LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3559
Local Reg. No. 7
Reg. Dist. No. 340 341

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gem 23
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 13 Idaho
b. COUNTY: Gem 23
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 800 Evergreen Drive

3. NAME OF DECEASED (Type or Print)
a. (First): Francisca
b. (Middle): 085
c. (Last): Barroetabena

4. DATE OF DEATH (Month) (Day) (Year): Aug. 6, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Dec. 25, 1892
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR Months: 7 Days: 11 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Ondarron, Vizcaya, Spain
12. CITIZEN OF WHAT COUNTRY?: Spain

13. FATHER'S NAME: Castro Solabarieta — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: Castora, Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.: $18-07-3204D
17. INFORMANT'S OWN SIGNATURE: X Earl Hatton — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occulsion — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Previous Coronary — 2 months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-29, 19 67, *to* 8-6-67, 19 ____, *that I last saw the deceased alive on* 8-6, 19 67, *and that death occurred at* 7:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Harmon E. Halverson 241 — (Degree or title): MD
23b. ADDRESS: Emmett, Idaho
23c. DATE SIGNED: 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Aug 9 1967
REGISTRAR'S SIGNATURE: Jean C. Beatty
25. EMBALMER: Glenn W. Beatty — LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendent. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3560
Local Reg. No.
Reg. Dist. No. 340 341

BIRTH NO.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) 4 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 212 So. Commercial 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 231
b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 212 So. Commercial

3. NAME OF DECEASED (Type or Print) a. (First) Alma b. (Middle) Laura c. (Last) Dolphin

4. DATE OF DEATH (Month) (Day) (Year) August 7, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Jan. 1, 1881

9. AGE (In years last birthday) 86 IF UNDER 1 YEAR Months 7 Days 6 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) teacher 12

10b. KIND OF BUSINESS OR INDUSTRY education

11. BIRTHPLACE (State or foreign country) Claremont, Minn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas F. Gibbons BIRTHPLACE Minn.

14. MOTHER'S MAIDEN NAME Laura C. Wright BIRTHPLACE Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-38-3949

17. INFORMANT'S OWN SIGNATURE X Laura C. Dolphin ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occulsion — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4201

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-7- *, 19* 55 *, to* 8-7 *, 19* 67 *, that I last saw the deceased alive on* 7-10 *, 19* 67 *, and that death occurred at* 6:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 241 Johnson E. Holverson MD

23b. ADDRESS Emmett, Idaho

23c. DATE SIGNED 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Aug. 10, 1967

24c. NAME OF CEMETERY OR CREMATORY Emmett

24d. LOCATION (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. Aug 9, 1967

REGISTRAR'S SIGNATURE Jean W Beatty

25. EMBALMER Glenn W Beatty

LICENSE NO. E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 12 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 16 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 13 1997

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3561
Local Reg. No. 10
Reg. Dist. No. 240-341

BIRTH NO.

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 23
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 1 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 217 Lincoln

3. NAME OF DECEASED (Type or Print)
a. (First): Minnie
b. (Middle): Viola 085
c. (Last): Millard

4. DATE OF DEATH (Month) (Day) (Year): Aug. 10, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Nov. 18, 1903

9. AGE (In years last birthday): 63 | IF UNDER 1 YEAR Months: 8 | Days: 22 | IF UNDER 24 HRS. Hours: | Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Lander, Wyoming

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Isaac Newton Burnett
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Rachael Robinson
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 521-22-4936

17. INFORMANT'S OWN SIGNATURE: X Wanda M. Schuldt
ADDRESS: 89 S.W. 2nd St. Ontario Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion ?
INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug 10, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 12:45 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 184 (Degree or title) MD
23b. ADDRESS: Emmett, Ida.
23c. DATE SIGNED: 16 Aug. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Aug 16, 1967
REGISTRAR'S SIGNATURE: Jean C Beatty
25. EMBALMER: Jean C Beatty
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3562
Local Reg. No. 13
Reg. Dist. No. 340-34

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Gem — SEP 8 1967 — 231 — 3-14
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett — LENGTH OF STAY (in this place): 2WKS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital — 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Gem — 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 517 West 3rd St

3. NAME OF DECEASED (Type or Print): a. (First) Wilbur — b. (Middle) Oscar — c. (Last) Adair

4. DATE OF DEATH (Month) (Day) (Year): Aug. 22, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Oct. 30, 1885

9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Columbus, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Adair — BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Drusilla Bruger — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 531 32 4995 A

17. INFORMANT'S OWN SIGNATURE: X W. O. Adair — ADDRESS: Seattle Wn.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

446X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nephrosclerosis & uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) — 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1955, *to* Aug 22, 1967, *that I last saw the deceased alive on* Aug 20, 1967, *and that death occurred at* 8:2[illegible] *pm., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm B. Jewell MD 260 — 23b. ADDRESS: 107 N. Comm, Emmett, Ida — 23c. DATE SIGNED: 8-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial — 24b. DATE: Aug. 25, 1967 — 24c. NAME OF CEMETERY OR CREMATORY: Emmett — 24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Sept. 1, 1967 — REGISTRAR'S SIGNATURE: Jean G Beatty — 25. EMBALMER: Glenn W Beatty — LICENSE NO.: E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 15 1986

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3563
Local Reg. No. 11
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED SEP 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gem 23
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place): 9days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 23
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Benjamin b. (Middle) DeForest c. (Last) Howard

4. DATE OF DEATH (Month) (Day) (Year): August 23, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Oct, 27, 1886

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Jamestown, No. Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Allen M. Howard
BIRTHPLACE: New York

14. MOTHER'S MAIDEN NAME: Ida M. Muzzy
BIRTHPLACE: Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-12-9144

17. INFORMANT'S OWN SIGNATURE: X DeForest Howard
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5702

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhagic infarction of

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) segment of small Bowel Mesenteric thrombosis

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 36 hours

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* Aug 23, 1967, *that I last saw the deceased alive* Aug 23, 1967, *and that death occurred at* 12 30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Kendall P. Newhouse 429 (Degree or title)

23b. ADDRESS: Emmett Ida

23c. DATE SIGNED: 8/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Aug. 25, 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Aug 30, 1967

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 5 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3564
Local Reg. No. 12
Reg. Dist. No. 340-341

Certificate of Death

RECEIVED
SEP 8 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett, Idaho
c. STATE OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D O A At Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): 1224 Main

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): HOWARD
c. (Last): HUTCHINSON

4. DATE OF DEATH (Month) (Day) (Year): 8 30 67

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: April 15, 1915
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Mitchell, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John T. Hutchinson — BIRTHPLACE: Louisville, Ky.
14. MOTHER'S MAIDEN NAME: Mary E Douthitt — BIRTHPLACE: Wirt, Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Two 4
16. SOCIAL SECURITY NO.: 507-12-3151
17. INFORMANT'S OWN SIGNATURE: Mrs H. T. Naylor — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary — INTERVAL BETWEEN ONSET AND DEATH: 5 mins

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Never, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 3 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Glenn W Beatty 583 4 Coroner
23b. ADDRESS: Gem County Emmett Idaho
23c. DATE SIGNED: 9-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 9/2/1967
24c. NAME OF CEMETERY OR CREMATORY: Joplin
24d. LOCATION (City, town, or county) (State): Near Boise

DATE REC'D BY LOCAL REG.: Sept 1, 1967
REGISTRAR'S SIGNATURE: Jean A. Beatty
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E 392

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 15 1990

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3565
Local Reg. No. 2183
Reg. Dist. No. 420

BIRTH NO.

RECEIVED AUG 10 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell 000
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho. 240
b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) Maude b. (Middle) L. c. (Last) Douglas

4. DATE OF DEATH (Month) (Day) (Year): Aug. 2 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Oct. 29, 1878

9. AGE (In years last birthday): 88
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Alma, Nebraska.

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: James Salmon — BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Rebecca Jones — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None 519-03-9240

17. INFORMANT'S OWN SIGNATURE: Peggy Gabriel — ADDRESS: Gooding, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arterio sclerosis & heart disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes mellitus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

260X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-31- 1966, *to* 8-2- 1967, *that I last saw the deceased alive on* 8-1- 1967, *and that death occurred at* 6:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Maurice E. Schuel MD

23b. ADDRESS: Wendell, Idaho

23c. DATE SIGNED: 8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 4, 1967

24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery

24d. LOCATION (City, town, or county) (State): Gooding, Gooding, Idaho.

DATE REC'D BY LOCAL REG.: Aug 8, 1967

REGISTRAR'S SIGNATURE: Helene J. Meyer

25. EMBALMER: Robert L. Meyer — LICENSE NO.: E-424

FIRM NAME: Thompson Chapel 137 Main Gooding Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3566
Local Reg. No. 2988
Reg. Dist. No. 420

RECEIVED
240 AUG 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding — 3-15
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (in this place): 15 days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 431 b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho Tuberculosis & Chest Dis. Hosp.
d. STREET ADDRESS (If rural, give location): 334 Highland Ave.

3. NAME OF DECEASED (Type or Print): a. (First) PAUL b. (Middle) B. 091 c. (Last) PATTERSON

4. DATE OF DEATH: (Month) August (Day) 3 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed 2	3-20-05	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Iron moulder (ret.)	21 Steel	Greenburg, Indiana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Patterson	Kentucky	Estella Green	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	312-01-8857	Hospital Records, I.W. Morris M.D.	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: several years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIsignificant CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Silicotuberculosis, far advanced, active — several years

4200

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 18, 1967, *to* Aug. 3, 1967, *that I last saw the deceased alive on* Aug. 2, 1967, *and that death occurred at* 7:12 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
I.W. Morris	598 M.D.	Tyler Hall, Gooding, Ida	8-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-5-67	Twin Falls Cemetery	Twin Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
8-4-67	Robert S. Meyer	Robert S. Meyer Thompson Chapel	C. 424

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

Dr. M. V. Klingler.

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3567
Local Reg. No. 2981
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240 AUG 21 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (If outside corporate limits, write RURAL and give township): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 945 Wyoming St.

3. NAME OF DECEASED (Type or Print)
a. (First): Carrie
b. (Middle): Belle 090
c. (Last): Wright

4. DATE OF DEATH (Month) (Day) (Year): Aug. 4, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct. 3, 1881
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 01
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A

13. FATHER'S NAME: Thomas H. Shore — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Sarah A. Mahoney — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-01-2749d
17. INFORMANT'S OWN SIGNATURE: William L. Evan — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hr.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic Heart Disease with failure.
DUE TO (c): Hypertension, arterosclerotic.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Obesity.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 18, 1967 *to* August 4, 1967, *that I last saw the deceased alive on* August 4, 1967, *and that death occurred at* 8:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marvin V. Klingler M.D. 285
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: August 6, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding Idaho

DATE REC'D BY LOCAL REG.: 8-10-67
REGISTRAR'S SIGNATURE: Robert S. Negus
25. EMBALMER: Eddie G. Lisch
LICENSE NO.: E-511

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Thompson Chapel - 737 Main St. - Gooding Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept 18, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3568 2984
Local Reg. No. 420
Reg. Dist. No.

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gooding 240 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Idaho 240 b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): South Route #2

3. NAME OF DECEASED (Type or Print): a. (First) Carrie b. (Middle) Lane 090 c. (Last) Wood

4. DATE OF DEATH (Month) (Day) (Year): August 5, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 24, 1913

9. AGE (In years last birthday): 54 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Stotesbury, Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Bert A. Powell — BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Grace Gregg — BIRTHPLACE: Grain Valley, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no None

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Robert S. Meyer — ADDRESS: Gooding, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident (Stroke) — INTERVAL BETWEEN ONSET AND DEATH: 3 d.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension, essential
Obesity, Gout, Diabetes Mellitus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug 3, 19 67, *to* August 5, 1967, *that I last saw the deceased alive on* Aug 4, 19 67, *and that death occurred at* 1:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marion V. Klingler, M.D. 285
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: Aug 7, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-10-67
REGISTRAR'S SIGNATURE: Robert S. Meyer
25. EMBALMER: Eddie G. Leach
LICENSE NO.: E-511

FIRM NAME: Thompson Chapel, Gooding, Idaho

Federal Security Agency
United States Public Health Service
Form DH-69021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

REC

SEP 18 1967

Bureau of Vital Statistics

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death) for Carrie Lane Wood (Name on Original Certificate) who died (Was Born or Died) on August 5, 1967 (Date of Event) in Gooding, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#8- Date of Birth	March 24, 1967	March 24, 1913

Subscribed and sworn to before me this 14th day of September, 1967

Carol C. Meyer

Notary Public, residing at Gooding, Idaho

My commission expires March 1, 1968

(Seal)

Signed Robert S. Meyer (Funeral director)

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person)

737 Main St. Gooding Idaho

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Gooding }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 14th day of September, 1967

Carol C. Meyer

Notary Public, residing at Gooding

My commission expires March 1, 1968

(Seal)

Signed Eddie G. Leach

(Signature of Any Credible Person)

1017 Wyoming St. Gooding, Idaho

(Street Address, City, State)

FORM DH 60-155 2 copies pd Rec 20622 9-13-67

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

SEP 18 1967

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... Certificate No. .....

County of ..... ss. .....

The Filed .....

(Name of Person) Carrie Lane Wood (Birth or Death) died on August 5, 1967

(Place of Birth) Gooding, Idaho

(Place of Birth) ..... are erroneous to be wrong in the land of his knowledge, the

(Place of Birth) ..... prepared on ..... are:

(Place of Birth) ..... Date of Birth March 24, 1967 March 24, 1913

Subscribed or sworn to before me ..... day of .....

Signed ..... Signature of Any Credible Person

Notary Public, residing at .....

My commission expires .....

(Seal) ..... Seal Address, City, State

Form DH 60-155

Marion Klingler

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 2984
Reg. Dist. No. 420

BIRTH NO.

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. IF NOT IN CITY OR TOWN, LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): South Route #2

3. NAME OF DECEASED (Type or Print): a. (First) Carrie b. (Middle) Lane c. (Last) Wood

4. DATE OF DEATH: (Month) Aug. (Day) 5, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: March 24, 1967
9. AGE (In years last birthday): 54
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Stotesbury, Mo.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bert A. Powell
BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Grace Gregg
BIRTHPLACE: Grain Valley, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Ralph S. Meyer
ADDRESS: Thompson Chapel Gooding, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident (Stroke)
INTERVAL BETWEEN ONSET AND DEATH: 3 d.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension, essential
Obesity, Gout, Diabetes Mellitus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 3, 1967, *to* August 5, 1967, *that I last saw the deceased alive on* Aug 4, 1967, *and that death occurred at* 1:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marion C. Klingler MD
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: Aug. 7, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-10-67
REGISTRAR'S SIGNATURE: Robert Meyer
25. EMBALMER: Eddie D. Leach
LICENSE NO.: E-511
FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 18 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Scheel

Certificate of Death

State File No. 3569
Local Reg. No. 2985
Reg. Dist. No. 420

BIRTH NO.

RECEIVED

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Gooding 240 AUG 21 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
c. LENGTH OF STAY (in this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Anna
b. (Middle): Storm
c. (Last): Fink

4. DATE OF DEATH (Month) (Day) (Year): Aug. 5, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 26, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Wautoma, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Storm — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-54-1523
17. INFORMANT'S OWN SIGNATURE: Thompson Chapel Records — ADDRESS: Gooding, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Vascular Accident	5 min
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	atherosclerosis	15 yrs
DUE TO (c)	Hypertension	20 yrs
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 Jul, 1967, *to* 5 Aug, 1967, *that I last saw the deceased alive on* 5 Aug, 1967, *and that death occurred at* 3 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard E. Short M.D.
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: 10 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county): Gooding, (State): Idaho

DATE REC'D BY LOCAL REG.: 8-12-67
REGISTRAR'S SIGNATURE: Robert S. Meyer
25. EMBALMER: Robert S. Meyer
LICENSE NO.: E-424

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
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ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

STATE OF IDAHO

State File No. 3570
Local Reg. No. 287
Reg. Dist. No. 420

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 240 GOODING
b. CITY OR TOWN: WENDELL
c. LENGTH OF STAY IN THIS PLACE: 10 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION: HOME 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 240 GOODING
c. CITY OR TOWN: WENDELL
d. STREET ADDRESS (If rural, give location): RURAL 3½ W.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MINNA	AMELIA	SCHMIDT	AUG. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
F	W	MARRIED 3	JULY 28, 1904	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE 01	DOMESTIC	ROCK SPRINGS WYO.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
FRED JACOB	GERMANY	MELBINA SACHAN	GERMANY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S SIGNATURE	ADDRESS
NO	NO	[redacted] Schmidt	Wendell Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute myocardial infarction sudden — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) pulmonary infarct
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-10-, 1965, *to* 8-9-, 19 67, *that I last saw the deceased alive on* 7-27-, 1967, *and that death occurred at* 7:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Maurice E. Schuel MD	Wendell, Idaho	8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL 3	8/11/1967	SHELLEY	CITY IDAHO:

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-19-67	Robert D. Meyer	J. Forrest Weaver	E 353

FIRM NAME: Weaver mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Klingler

Certificate of Death

STATE OF IDAHO

State File No. 3571
Local Reg. No. 2988
Reg. Dist. No. 420

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gooding, 240 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gooding Co. Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240 b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) 210 Main St.

3. NAME OF DECEASED (Type or Print) a. (First) Jessie b. (Middle) May 090 c. (Last) Palmer

4. DATE OF DEATH (Month) (Day) (Year) Aug. 9, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2.

8. DATE OF BIRTH Oct. 20, 1878

9. AGE (In years last birthday) 88 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boarding House Operator 22

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cameron, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jasper L. James BIRTHPLACE Summit Grove, Ind.

14. MOTHER'S MAIDEN NAME Alice Wait BIRTHPLACE Highland, Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-38-1527

17. INFORMANT'S OWN SIGNATURE ADDRESS Thompson Chapel Records-Gooding, Ida.

331X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident (Stroke) — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute gastro-enteritis.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 5, 1967, *to* August 9, 1967, *that I last saw the deceased alive on* August 9, 1967, *and that death occurred at* 7:20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 285
23b. ADDRESS Gooding, Idaho
23c. DATE SIGNED 8-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-14-1967
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) Gooding (State) Gooding, Idaho

DATE REC'D BY LOCAL REG. 8-15-67
REGISTRAR'S SIGNATURE Raleen S. Meyer
25. EMBALMER Eddie G. Leach LICENSE NO. E-511
FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 24 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3572
Local Reg. No. 2986
Reg. Dist. No. 420

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 24 2-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (in this place): 6 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho Tuberculosis + Chest Dis. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 188
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe
d. STREET ADDRESS (If rural, give location): Box 142

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	CHARLES	RAY	BARRY	8	11	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	single	2-18-93	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Rancher + logger
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Louis Barry — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Lucy Fiedler — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 518-16-8065A
17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Hospital Records, L.W. Morris M.D.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the Colon — INTERVAL BETWEEN ONSET AND DEATH: several months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary tuberculosis, mod. advanced active; Arteriosclerotic heart disease.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-8, 1967, *to* 8-11, 1967, *that I last saw the deceased alive on* 8-11, 1967, *and that death occurred at* 6:40 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: L.W. Morris 598 (Degree or title) M.D.
23b. ADDRESS: Box 481 Gooding, Ida.
23c. DATE SIGNED: 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-14-67
24c. NAME OF CEMETERY OR CREMATORY: Old Fine Cemetery
24d. LOCATION (City, town, or county) (State): Cremation Co. Idaho

DATE REC'D BY LOCAL REG.: 8-14-67
REGISTRAR'S SIGNATURE: Robert E. Meyer
25. FUNERAL DIRECTOR: Eddie Leach
ADDRESS: E-511

Thompson Chapel - Gooding, Idaho

Federal Security Agency
United States Public Health Service
Form DPH-40021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal or homicidal.

This body embalmed under direction of Eddie G. Finch Lic. No. E-511 at Thompson Chapel 8/11/67

ADDITIONAL REMARKS by Physician 727 MAIN ST

GOODING, IDAHO

State File No. 3573
Local Reg. No. 2987
Reg. Dist. No. 420

Certificate of Death

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. VENUE OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho Tuberculosis + Chest Dis. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 180
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): Arcadian Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First): MOOSES
b. (Middle): 091
c. (Last): NIEMI

4. DATE OF DEATH (Month) (Day) (Year): 8 - 11 - 67

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 12-31-86
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumbering
11. BIRTHPLACE (State or foreign country): Finland
12. CITIZEN OF WHAT COUNTRY? Finland

13. FATHER'S NAME: Matt Niemi — BIRTHPLACE: Finland
14. MOTHER'S MAIDEN NAME: Mary — BIRTHPLACE: Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-03-9255
17. INFORMANT'S OWN SIGNATURE: Hospital Records — ADDRESS: S. W. Moris M.D.

18. CAUSE OF DEATH 1621
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: one year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus + hemiplegia — 15 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-19, 1966, *to* 8-11, 1967, *that I last saw the deceased alive on* 8-10, 1967, *and that death occurred at* 4:10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: S. W. Moris 598 (Degree or title): M.D.
23b. ADDRESS: Box 481 Gooding, Ida.
23c. DATE SIGNED: 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/16/67
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding - Gooding Idaho

DATE REC'D BY LOCAL REG.: 8-14-67
REGISTRAR'S SIGNATURE: Robert S. Meyer
25. FUNERAL DIRECTOR: Eddie G. Leach — ADDRESS: E-511 Thompson Chapel - Gooding, Idaho

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of Eddie G. Leach Lic. No. E-511 at Thompson Chapel on 8/11/67

ADDITIONAL REMARKS by Physician 737 Main Gooding, Idaho

Dr. M. V. Klingler

Certificate of Death

STATE OF IDAHO

State File No. 3574
Local Reg. No. 294
Reg. Dist. No. 420

BIRTH NO.

REC AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gooding 240 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gooding County Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240 b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) 1410 Calif. St. H. J. Rodabaugh Gooding, Idaho.

3. NAME OF DECEASED (Type or Print) a. (First) Corwin b. (Middle) R 090 c. (Last) Heinlein

4. DATE OF DEATH (Month) (Day) (Year) August 12 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 5, 1871
9. AGE (In years last birthday) 96 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Logan County, Ohio
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME James Heinlein BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) None 502-34-6605
17. INFORMANT'S OWN SIGNATURE E. Leach (Thompson Chapel Records) ADDRESS Gooding, Idaho.

4200

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, Bilat, lower lobs — INTERVAL BETWEEN ONSET AND DEATH: 2-3 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease with failure. — 3 weeks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. senility.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-12-67, 19___, *to* 8-12-67, 19___, *that I last saw the deceased alive on* 8-12-67, 19___, *and that death occurred at* 5:00 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE Marvin V Klingler Me (Degree or title) 285
23b. ADDRESS Gooding, Idaho
23c. DATE SIGNED 8-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-18-67
24c. NAME OF CEMETERY OR CREMATORY Lansford, Cemetery
24d. LOCATION (City, town, or county) (State) Lansford, North Dakota.

DATE REC'D BY LOCAL REG. 8-23-67
REGISTRAR'S SIGNATURE Robert S Meyer
25. EMBALMER Robert S Meyer LICENSE NO. E-424
FIRM NAME: Thompson Chapel Gooding, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Schleel —

Certificate of Death

STATE OF IDAHO

State File No. 3575
Local Reg. No. 2990
Reg. Dist. No. 420

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gooding 240 200
b. CITY OR TOWN Wendell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240
b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Julia b. (Middle) Mabel c. (Last) Woody

4. DATE OF DEATH (Month) (Day) (Year) August 18 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 2
8. DATE OF BIRTH Jan 11, 1892
9. AGE (In years last birthday) 74 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Chadron, Nebraska.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Abraham Lyons Gilmore BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Rachel Devor BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-40-6393
17. INFORMANT'S OWN SIGNATURE X Pearl Fredericksen ADDRESS Gooding, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4-20-1

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) art sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-30- *19* 63, *to* 8-18-67, *19* ___, *that I last saw the deceased alive on* 8-18- *19* 67, *and that death occurred at* 1:40p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 4576 Maurice E. Schleel MD
23b. ADDRESS Wendell, Idaho
23c. DATE SIGNED 8-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-22-1967
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) Gooding (State) Gooding Idaho.

DATE REC'D BY LOCAL REG. Aug 23 1967
REGISTRAR'S SIGNATURE Robert L. Meyer
25. EMBALMER Robert L. Meyer
LICENSE NO. C-424
FIRM NAME: Thompson Chapel Gooding Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 16 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. M. V. Klingler

Certificate of Death

STATE OF IDAHO

State File No. 3576
Local Reg. No. 2992
Reg. Dist. No. 420

BIRTH NO.

AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hospital.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho. 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): Route #2

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): 090
c. (Last): Johnson

4. DATE OF DEATH: (Month) Aug. (Day) 20, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: May 11, 1897

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stockman & Rancher

10b. KIND OF BUSINESS OR INDUSTRY: & Mech.

11. BIRTHPLACE (State or foreign country): Moore, Idaho

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Algott Johnson 04
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Hilma Peterson
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-42-7171

17. INFORMANT'S OWN SIGNATURE: Eddie S. Leach
ADDRESS: Thompson Chapel Records:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5795

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Generalized Peritonitis, secondary to operation for intestinal obstruction — INTERVAL BETWEEN ONSET AND DEATH: 8 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Recurrent partial Intestinal obstruction with intestinal ileus. — 24 hrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Abcess of right upper lung, secondary to septicemia.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* August 7, 1967, *to* August 20, 1967, *that I last saw the deceased alive on* August 20, 19 67, *and that death occurred at* 2:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marion V. Klingler MD 285
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: 8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-23-67
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: 8-23-67
REGISTRAR'S SIGNATURE: Valeen D. Meyer
25. EMBALMER: Eddie S. Leach
LICENSE NO.: E-511
FIRM NAME: Thompson Chapel Gooding, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Ely Short-

Certificate of Death

STATE OF IDAHO

State File No. 3577
Local Reg. No. 2993
Reg. Dist. No. 420

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gooding 240 000
b. CITY OR TOWN Wendell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wendell Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240 b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) 825 Oregon Street

3. NAME OF DECEASED (Type or Print) a. (First) Loren b. (Middle) William c. (Last) Reynolds

4. DATE OF DEATH (Month) (Day) (Year) August 23 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 24, 1917
9. AGE (In years last birthday) 50 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body and Fender Repairman 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Acequia, Idaho.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME William Marion Reynolds BIRTHPLACE Pantuitch Utah.
14. MOTHER'S MAIDEN NAME Mary Helena Jensen BIRTHPLACE Lewiston, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II
16. SOCIAL SECURITY 519-07-7000
17. INFORMANT'S OWN SIGNATURE X Zelpha M. Reynolds ADDRESS Gooding, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

237X4

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral neoplasm — INTERVAL BETWEEN ONSET AND DEATH 4 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 26 Jul, 1967, to 23 Aug, 1967, *that I last saw the deceased alive on* 23 Aug, 1967, *and that death occurred at* 7:25 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward Leach MD (Degree or title)
23b. ADDRESS Gooding Idaho
23c. DATE SIGNED 24 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-26-1967
24c. NAME OF CEMETERY OR CREMATORY Elmwood Cemetery
24d. LOCATION (City, town, or county) (State) Gooding Gooding Idaho.

DATE REC'D BY LOCAL REG. 8-26-67
REGISTRAR'S SIGNATURE Valeen Meyer
25. EMBALMER Eddie D. Leach
LICENSE NO. E-511

FIRM NAME: Thompson Chapel - Gooding, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 15 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3578
Local Reg. No. 2995
Reg. Dist. No. 420

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 240 SEP 14 1967 3-01
a. COUNTY Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
c. LENGTH OF TIME (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Manor 253

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 161
b. COUNTY CASSIA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BURLEY
d. STREET ADDRESS (If rural, give location) 1901 SCHODDE ST.

3. NAME OF DECEASED (Type or Print)
a. (First) Anna
b. (Middle)
c. (Last) Gini

4. DATE OF DEATH (Month) (Day) (Year) Aug. 28, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Oct. 12, 1879
9. AGE (In years last birthday) 87 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Villa De Chavera, Italy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Andrew Snyder — BIRTHPLACE Italy
14. MOTHER'S MAIDEN NAME Frances UNK. — BIRTHPLACE Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NO
17. INFORMANT'S OWN SIGNATURE Mrs Frank L Price — ADDRESS 1901 Schodde St. Burley Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — 5-10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-16, 1963, *to* 8-28, 1967, *that I last saw the deceased alive on* 8-28, 1967, *and that death occurred at* 5:20 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE A B Kircher 283 (Degree or title) MD
23b. ADDRESS Burley Idaho
23c. DATE SIGNED 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
24b. DATE 8/31/1967
24c. NAME OF CEMETERY OR CREMATORY CHALLIS
24d. LOCATION (City, town, or county) CHALLIS (State) IDAHO.

DATE REC'D BY LOCAL REG. 9-9-67
REGISTRAR'S SIGNATURE Robert S. Meyer
25. EMBALMER J. Forrest Weaver — LICENSE NO. E 353
FIRM NAME: Weaver mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 22 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3579
Local Reg. No. 49
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 11 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
d. STREET ADDRESS (If rural, give location): Box 183 Kamiah, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): JANE
b. (Middle): ALLEN
c. (Last): OATMAN

4. DATE OF DEATH (Month) (Day) (Year): Aug 2, 1967

5. SEX: Female
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 1, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Myrtle, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Allen — BIRTHPLACE: Alpowa
14. MOTHER'S MAIDEN NAME: Emma Thompson — BIRTHPLACE: Asotin, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs Melvin Majorne — ADDRESS: Kamiah, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Post-Hepatitis Cirrhosis — unkn
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death*: Chronic mitral and Tricuspid valvulitis, arteriosclerosis, Pulmonary Emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 oct, 1960, *to* 2 aug, 1967, *that I last saw the deceased alive on* 2 aug, 1967, *and that death occurred at* 6:55A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Morrison 373 MD
23b. ADDRESS: Grangeville, Id
23c. DATE SIGNED: 8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/5/67
24c. NAME OF CEMETERY OR CREMATORY: Tribal
24d. LOCATION (City, town, or county) (State): Kamiah, Idaho

DATE REC'D BY LOCAL REG.: Aug 22, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — LICENSE NO. E 433
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: OCT 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 3580
Local Reg. No. 48
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 250 Idaho — SEP 8 1967 — 2-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville — STAY (in this place) 4 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Hill Nursinghome 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) Star Rt South Fork

3. NAME OF DECEASED (Type or Print) — a. (First) VIOLET — b. (Middle) ANITA — c. (Last) ALDOUS

4. DATE OF DEATH (Month) (Day) (Year) August 11, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married
8. DATE OF BIRTH: December 10, 1897
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Wasco County, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oliver H Kerns — BIRTHPLACE: Washington
14. MOTHER'S MAIDEN NAME: Myrtle Patterson — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 267-34-9183
17. INFORMANT'S OWN SIGNATURE: Herbert Aldous — ADDRESS: Grangeville, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2377 Probable Cerebral tumor — INTERVAL BETWEEN ONSET AND DEATH: 6-8 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema — Several years.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* about, 1955, *to* 11 Aug, 1967, *that I last saw the deceased alive on* 10 Aug, 1967, *and that death occurred at* 3:45 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Donald Altman (Degree or title) 487 — 23b. ADDRESS: Grangeville, Idaho — 23c. DATE SIGNED: 30 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 8/14/67 — 24c. NAME OF CEMETERY OR CREMATORY: Prairieview — 24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept 5, 1967 — REGISTRAR'S SIGNATURE: Irma Cone — 25. EMBALMER: Robert H Hansen — LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 13 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3581
Local Reg. No. 781
Reg. Dist. No. 244

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 1-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
LENGTH OF STAY (in this place): 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home - 2 mi. SE. of Kamiah

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
d. STREET ADDRESS (If rural, give location): 2 miles S.E. of town

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Amzel	A.	Sanford	August 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 1 DAY: Hours / Min.
Female	white	2 Widowed	June 8, 1896	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wife - Mother O/	Own home	Kamiah, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Robinett	Oregon	Evaline Ingram	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Nora Mansey	Kooskia, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* not seen, 19, *to* Sep 8, 19, *that I last saw the deceased alive on* Sept 8, 19, *and that death occurred at* 10:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Milton H. Wilcox MD	Grangeville Idaho	Sept 9 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 18, 1967	Kamiah	Kamiah Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 9 1967	Dorothy Mowry	Robert R. Hansen	E193

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3582
Local Reg. No. 44
Reg. Dist. No. 240

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): Hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Rt # 2

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): RALPH 092
c. (Last): LOUIS

4. DATE OF DEATH (Month) (Day) (Year): August 14, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 4 Divorced
8. DATE OF BIRTH: October 5, 1939
9. AGE (In years last birthday): 27 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Grangeville, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harry B Louis — BIRTHPLACE: Dillon, Montana
14. MOTHER'S MAIDEN NAME: Francis June Lewis — BIRTHPLACE: Yakima, Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1960-1964 8
16. SOCIAL SECURITY NO.: 519 36 2883
17. INFORMANT'S OWN SIGNATURE: Mrs Jun Edwards PH. — ADDRESS: Grangeville, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8230

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Head injury - based skull fracture

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): —
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): auto
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Koochin 250 Idaho, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8/13/67 5:30 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Pickup rolled

22. *I hereby certify that I attended the deceased from* 8/13, 1967, *to* 8/14, 1967, *that I last saw the deceased alive on* 8/14, 1967, *and that death occurred at* 03:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] p 444 MD
23b. ADDRESS: Grangeville Idaho
23c. DATE SIGNED: 8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Aug. 22 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hanson — LICENSE NO.: E433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 22 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3583
Local Reg. No. 47
Reg. Dist. No. 240

RECEIVED
SEP 8 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 3-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): one week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Farm in Columbes District

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle): A 092
c. (Last): LIBBY

4. DATE OF DEATH (Month) (Day) (Year): August 14, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single /
8. DATE OF BIRTH: February 12, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): State of Maine
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Laura A Lord — BIRTHPLACE: Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW#1 3
16. SOCIAL SECURITY NO.: 519 30 9149
17. INFORMANT'S OWN SIGNATURE: Robert R. Hansen, Hosp Records — ADDRESS: Grangeville, Idaho

8254

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Chest injuries — few days
DUE TO (c) auto accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/7, 1967, *to* 8/14, 1967, *that I last saw the deceased alive on* 8/14, 1967, *and that death occurred at* 11:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald Altman 487 M.D.
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 30 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/17/67
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept 5 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R. Hansen — Robert R. Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 20 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3584
Local Reg. No. 12
Reg. Dist. No. 242

Certificate of Death

RECEIVED SEP 8 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (If in place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kenterville
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First): Fr. Benedict
b. (Middle): R.
c. (Last): Demerath

4. DATE OF DEATH (Month) (Day) (Year): Aug 15 67

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Mar 25 1916
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Religious Priest 18
10b. KIND OF BUSINESS OR INDUSTRY: Parish Administator
11. BIRTHPLACE (State or foreign country): Appleton, Wisconsin
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Jacob R. Demerath — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mgr. M. F. Verhoeven — ADDRESS: Cottonwood

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Probably Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Not known. Not attended previously
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Not attended *to* —, 19__, *that I last saw the deceased alive on* D.O.A., 19__, *and that death occurred at* 4:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. F. Orr, M.D. 399
23b. ADDRESS: Cottonwood, Idaho
23c. DATE SIGNED: 8-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: August 18 67
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): De Pere, Wisconsin

DATE REC'D BY LOCAL REG.: Aug. 17, 1967
REGISTRAR'S SIGNATURE: Wesley F. Orr, M.D. by M
25. EMBALMER: Clifford Uhlorn
LICENSE NO.: E421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3585
Local Reg. No. 13
Reg. Dist. No. 242

RECEIVED SEP 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 — 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (In this place): 15 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): San Francisco
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Gertrude b. (Middle) E. c. (Last) Keaney

4. DATE OF DEATH: (Month) Aug (Day) 19 (Year) 67

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: June 10 1893

9. AGE (In years last birthday): 74 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): San Francisco, Calif.

12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: George Zimmer — BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Mary Tobin — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 567 03 3086 A

17. INFORMANT'S OWN SIGNATURE: Sister Madeline Therese — ADDRESS: Pasco Wash.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Spastic Paraplegia — 10 yrs
DUE TO (c) Cerebral Arterio Sclerotic Heart Disease — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Parkinsons Syndrome

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3-15, 1966, *to* 8-19, 1967, *that I last saw the deceased alive on* 8-18, 1967, *and that death occurred at* 12:30 Am., *from the causes and on the date stated above.*

23a. SIGNATURE: K. H Collins 100 (Degree or title): M D

23b. ADDRESS: Gaig mont Idaho

23c. DATE SIGNED: 8-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug 21 67

24c. NAME OF CEMETERY OR CREMATORY: Catholic

24d. LOCATION (City, town, or county) (State): Cottonwood Idaho

DATE REC'D BY LOCAL REG.: 8-31-67

REGISTRAR'S SIGNATURE: W. F. Orr M.D. by m

25. EMBALMER: Uhlorn

LICENSE NO.: E 421

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3586
Local Reg. No. 46
Reg. Dist. No. 240

BIRTH NO.

SEP 8 1967

Bureau of Vital Statistics

1-01

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): one year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho County Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 404 N A Grangeville

3. NAME OF DECEASED (Type or Print)
a. (First): Tillman
b. (Middle): 276
c. (Last): Bowman

4. DATE OF DEATH (Month) (Day) (Year): August 20, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced, Widowed

8. DATE OF BIRTH: November 11, 1876

9. AGE (In years last birthday): 90
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Trail Boss 08

10b. KIND OF BUSINESS OR INDUSTRY: Forest Service

11. BIRTHPLACE (State or foreign country): Hillsville, Virginia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 62 3106

17. INFORMANT'S OWN SIGNATURE: X Pete Fountain
ADDRESS: Moscow Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 6000 Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death Generalized atherosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* aug, 1966, *to* 20 aug, 1967, *that I last saw the deceased alive on* 20 aug, 1967, *and that death occurred at* 10:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald J. Eltman M.D
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 20 aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/22/67
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept. 5 1967
REGISTRAR'S SIGNATURE: Irma Cone

25. EMBALMER: Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

NOV 16 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 8 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3587
Local Reg. No. 45
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): one year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho County Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250 b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Grangeville, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) ALTA b. (Middle) VIOLA 276 c. (Last) PAUL

4. DATE OF DEATH (Month) (Day) (Year): August 22, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 21, 1888
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Thompson — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Elizabeth Olney — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 58 72341
17. INFORMANT'S OWN SIGNATURE: x Della Krebs — ADDRESS: Grangeville, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1962, *to* 22 aug, 1967, *that I last saw the deceased alive on* 22 aug, 1967, *and that death occurred at* 12:35P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Donald Altman 487 (Degree or title): M.D.
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 30 aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/25/67
24c. NAME OF CEMETERY OR CREMATORY: Harpster
24d. LOCATION (City, town, or county) (State): Harpster, Idaho

DATE REC'D BY LOCAL REG.: Sept 5 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3588
Local Reg. No. 475
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 — 1-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Golden — LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home In Golden, Idaho 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250 — b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Golden
d. STREET ADDRESS (If rural, give location): Golden Star Rt. Grangeville, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DAVID		BRAZIL	August 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Divorced 21	February 22, 1903	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Writer-Photographer	Writing	San Louis Obispo Calif.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW #1 3	518 24 8391	[signature]	Golden, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible] — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) [illegible]

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 588	[illegible] 5	[illegible]	8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/26/67	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 26 1967	Irma Cone	Robert R Hansen [signature]	E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 8 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3589
Local Reg. No. 244
Reg. Dist. No. 240

BIRTH NO. 3-06

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 212 South Hall Street

3. NAME OF DECEASED (Type or Print)
a. (First): CLIFTON
b. (Middle): DERBY 092
c. (Last): CUTTING

4. DATE OF DEATH: (Month) (Day) (Year): August 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: September 6, 1897
9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Owner 23
10b. KIND OF BUSINESS OR INDUSTRY: Drug
11. BIRTHPLACE (State or foreign country): Brattleboro, Vermont
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Starr W. Cutting
BIRTHPLACE: Brattleboro, Ver.
14. MOTHER'S MAIDEN NAME: Mary E. Derby
BIRTHPLACE: Springfield, Mass.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 721 18 8798 A
17. INFORMANT'S OWN SIGNATURE: X [signature] ADDRESS: Grangeville, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2923

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Subarachnoid Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myelofibrosis — Few years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* about 1962 *to* 28 aug, 1967, *that I last saw the deceased alive on* 28 aug, 1967, *and that death occurred at* 11:15 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Donald Altman (Degree or title) M. D.
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 31 aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/31/67
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept. 5, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R. Hansen [signature]
LICENSE NO.: E 433

FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Asael Call no

Certificate of Death

STATE OF IDAHO

State File No. 3590
Local Reg. No. 5
Reg. Dist. No. 640

BIRTH NO.

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jefferson 260 1-04
b. CITY OR TOWN: Rigby (Rural)
LENGTH OF STAY (in this place): 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Carson Nursing Home 097

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 061
b. COUNTY: Bingham
c. CITY OR TOWN: Blackfoot
d. STREET ADDRESS (If rural, give location): 198 Rogers St.

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Allen c. (Last) Clark

4. DATE OF DEATH (Month) (Day) (Year): August 18, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: August 7, 1876

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Retired) 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Vinton, Benton County, Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James LeRoy Clark
BIRTHPLACE: ?

14. MOTHER'S MAIDEN NAME: Delia Anklam
BIRTHPLACE: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-07-6037

17. INFORMANT'S OWN SIGNATURE: Paul W. Clark ADDRESS: Blackfoot, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart disease — years.

DUE TO (c) Cerebral arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. mental deterioration — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-20, 1963, *to* August 18, 1967, *that I last saw the deceased alive on* Aug 14, 1967, *and that death occurred at* 11:55a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Call, (Degree or title) M. D.

23b. ADDRESS: Rigby, Idaho

23c. DATE SIGNED: Aug. 21,-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 21, 1967

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: Aug 21 1967

REGISTRAR'S SIGNATURE: Myra B Cokesell

25. EMBALMER: John C. Sandberg — LICENSE NO.: E-280

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

amend items 13, 14 & 24c 5-30-86 dl

RECEIVED SEP 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3591
Local Reg. No. 7
Reg. Dist. No. 640

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 9 miles No. of Roberts
c. LENGTH OF STAY (in this place): inst.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway # 88 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Box 1368

3. NAME OF DECEASED (Type or Print): a. (First) Anthony b. (Middle) Alvin c. (Last) Nelson

4. DATE OF DEATH: August 26, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: Feb. 2, 1939

9. AGE (In years last birthday): 28 (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lawyer 16

10b. KIND OF BUSINESS OR INDUSTRY: Corporation

11. BIRTHPLACE (State or foreign country): Pine Bluff, Arkansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Carl Nelson BIRTHPLACE: Arkansas ~~Unknown~~

14. MOTHER'S MAIDEN NAME: Octavia ~~Bylery~~ Byerly BIRTHPLACE: Arkansas ~~Unknown~~

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): not available

16. SOCIAL SECURITY NO.: 520 38 8670

17. INFORMANT'S OWN SIGNATURE: Carl August Nelson ADDRESS: Wallace, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Severe Skull Fracture — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): car and truck accident

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway # 88

21c. (CITY, TOWN, OR TOWNSHIP) 260 **(COUNTY)** 13 9 miles No. Roberts Jefferson **(STATE)** Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): August 26 1967 ~~P.M.~~

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: car crashed into rear of truck-trailer

22. *I hereby certify that* ~~XXXX

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 12 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 5 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 17 1984

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics, Standards, and Local Health Services

AFFIDAVIT TO CORRECT OR AMEND AN ORIGINAL CERTIFICATE

MAY 07 1986

State of Idaho
County of Shoshone } ss.

Certificate No. D67-3591
Date Filed

Bureau ... ds and Local ... Services

The undersigned does solemnly swear that certain facts on the certificate of death

for Anthony Alvin Nelson (Name on Original Certificate) who died (Was Born, Died, etc.) on Aug 26, 1967 (Date of Event)

in Jefferson County (Place of Event) are erroneous or were omitted:

ITEMS TO BE CORRECTED	FROM	TO
Item 14 Mother's name	Octavia Bylery	Octavia Byerly ?
Mother's birthplace	Unknown	Benton, Arkansas
		SALINE CO AR.
fathers birth place	Unknown	Arkansas
cemetery where buried	Coeur d'Alene Cemetery	Restlawn Memorial Park

Subscribed and sworn to before me this 2nd day of May, 19 86

Notary Public, Betty Jo Fuller
Residing at Notary Public for the State of Idaho.
My commission expires Residing at Wallace, Idaho 83873
(Seal) My Commission expires 02 24 87

x Octavia Nelson
Signature of Applicant

Box 63. Wallace Ida. 83873
Street Address, City, State

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of _____
County of _____ } ss.

(Must be completed __)
(Is not necessary __)

The undersigned does solemnly swear that he has knowledge of the facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this _____ day of _____, 19__.

Notary Public, _____
Residing at _____
My commission expires _____
(Seal)

_____
Supporting Signature

_____
Street Address, City, State

4-14-86 General Corresp. "Octavia Nelson: fc

Marriage License from Arkansas lists Nancy Octavia Byerly of Arkansas and Carl August Nelson of Arkansas were married March 11, 1935 in Arkansas. Viewed by V.S.

MAY 30 1986

School REcord from U.Of I lists student as Anthony Alvin Nelson and father as Carl A Nelson and mother as Nancy Byerly Nelson. Obviously old record. Viewed by V.S.

Birth Certificate for Carl August Nelson born Jan 1, 1910 in Grady, Arkansas viled May 15, 1945. Viewed by V.S.

Birth Certificate for Nancy Octavia Byerly born April 28, 1917 in Arkansas filed May 1, 1917. Viewed by V.S.

Notarized statement from Coeur d'Alene Cemetery states that at the time of Anthony Alvin Nelson's burial the name of the cemetery was Restlawn Memorial Park . Viewed by V.S.

RECEIVED

SEP 5 1967

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3592

Local Reg. No. 2

Reg. Dist. No. 640

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Jefferson 260 1/2

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Menan (rural)

c. LENGTH OF STAY (in this place): 12 years

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4 mi. N.W. of Menan 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho 260 b. COUNTY: Jefferson

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Menan (rural)

d. STREET ADDRESS (If rural, give location): 4 Mi. N.W. of Menan

3. NAME OF DECEASED (Type or Print): a. (First) IRVIN b. (Middle) LEROY c. (Last) HANCOCK

4. DATE OF DEATH (Month) (Day) (Year): August 26, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 29, 1910

9. AGE (In years last birthday): 57 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Kilgore, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Hancock — BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Nancy Caroline Tevebaugh — BIRTHPLACE: Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-05-5847

17. INFORMANT'S OWN SIGNATURE: Verba J. Hancock — ADDRESS: Menan, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed chest — INTERVAL BETWEEN ONSET AND DEATH: Inst.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): farm 02

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Menan 13 Jefferson 260 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 26, 1967 5:30 p.m.

21e. INJURY OCCURRED: WHILE AT WORK ☒ / NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Crushed between grain combine and machine shed.

22. *I hereby certify that I attended the deceased from* [illegible] *that I last saw the deceased* [illegible] *death occurred at* 5:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE: 583 Menan Idaho (Degree or title): Coroner

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED: Aug. 28, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 29, 1967

24c. NAME OF CEMETERY OR CREMATORY: Little Butte

24d. LOCATION (City, town, or county) (State): Annis Jefferson Idaho

DATE REC'D BY LOCAL REG.: Aug 28 1967

REGISTRAR'S SIGNATURE: Mrs A B Eckersell

25. EMBALMER: Bruce A. Eckersell — Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23e and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3593
Local Reg. No. 1011
Reg. Dist. No. 440

BIRTH NO.

RECEIVED AUG 8 - 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 270
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome (Rural)
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print)
a. (First): CLARA
b. (Middle): BARTON 099
c. (Last): HOPKINS

4. DATE OF DEATH (Month) (Day) (Year): Aug. 3, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 29, 1898

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): St. Louis, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John T. Shirk
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Kate Smith
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 38 9691

17. INFORMANT'S OWN SIGNATURE: X C. B. Hopkins
ADDRESS: Rt. 2 Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 3 mos.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-23, 1963, *to* 8-3-, 1967, *that I last saw the deceased alive on* 8-2-, 1967, *and that death occurred at* 9:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Maurice E. Scheel M.D.

23b. ADDRESS: Wendell, Idaho

23c. DATE SIGNED: 8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Aug. 5, 1967

24c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Aug. 7 1967

REGISTRAR'S SIGNATURE: Louella M. Deherer

25. EMBALMER: W. L. Hove

LICENSE NO.: E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Holsinger

Certificate of Death

STATE OF IDAHO

State File No. 3594
Local Reg. No. 1012
Reg. Dist. No. 440

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record, typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN: Jerome
(If outside corporate limits, write RURAL and give Township)
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Marcelino
b. (Middle): 099
c. (Last): Laragan

4. DATE OF DEATH: (Month) Aug. (Day) 6, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 2

8. DATE OF BIRTH: June 18, 1888

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Sheep

11. BIRTHPLACE (State or foreign country): Vizcaya Prov. Arregoitia, Spain

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Victoriano Laragan
BIRTHPLACE: Spain

14. MOTHER'S MAIDEN NAME: Rafaela Geuzeroga
BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-36-7177

17. INFORMANT'S OWN SIGNATURE: X Maria Laragan
ADDRESS: Hagerman Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): my ocardial infarct
INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec 28, 1959, *to* 8-6-, 1967, *that I last saw the deceased alive on* 8-6-, 1967, *and that death occurred at* 10:a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Maurice E. Schad MD
23b. ADDRESS: Wendell Ida
23c. DATE SIGNED: 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 9 1967
24c. NAME OF CEMETERY OR CREMATORY: Hagerman Cemetery
24d. LOCATION (City, town, or county) (State): Hagerman, Idaho

DATE REC'D BY LOCAL REG.: Aug. 14 1967
REGISTRAR'S SIGNATURE: Louella M. Schad
25. EMBALMER: Robert L. Meyer
LICENSE NO.: E-424
FIRM NAME: Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3595
Local Reg. No. 1013
Reg. Dist. No. 440

BIRTH NO. RECEIVED STATE OF IDAHO

1. PLACE OF DEATH 270
a. COUNTY Jerome AUG 21 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome Bureau of Vital Statistics
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 515 7th. Ave. West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270 b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 515 7th. Ave. West

3. NAME OF DECEASED (Type or Print)
a. (First) RACHEL b. (Middle) MARIE c. (Last) MUFFLER

4. DATE OF DEATH (Month) (Day) (Year) Aug. 12, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 25, 1903
9. AGE (In years last birthday) 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book 01
10b. KIND OF BUSINESS OR INDUSTRY Restaurant
11. BIRTHPLACE (State or foreign country) Mayfield, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Christian Jensen BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Marie Gregorsen BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 528 42 7732
17. INFORMANT'S OWN SIGNATURE X John Robert Muffler ADDRESS Jerome, Idaho

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspirational asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: 3 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Vascular accident — 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 12:10 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Jon D. Wilmoth, M.D. 770
23b. ADDRESS 216 East Main; Jerome
23c. DATE SIGNED Aug. 16, '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. Aug. 17, 1967
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16, inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Scheer

Certificate of Death

STATE OF IDAHO

State File No. 3596
Local Reg. No. 7074
Reg. Dist. No. 440

RECEIVED AUG 23 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedicts Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240 b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Tuttle
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Lula b. (Middle) W. 099 c. (Last) Ravenscroft

4. DATE OF DEATH (Month) (Day) (Year) August 15, 1967

5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Sept. 1, 1873 | 9. AGE (In years last birthday) 93 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Housewife & Mistress | 10b. KIND OF BUSINESS OR INDUSTRY Post

11. BIRTHPLACE (State or foreign country) Eureka, Kansas | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Hawthorne | BIRTHPLACE Ireland

14. MOTHER'S MAIDEN NAME Agnes Conway | BIRTHPLACE Ship Board, Atlantic

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-58-8399

17. INFORMANT'S OWN SIGNATURE Flossie Rasmore | ADDRESS Wendell, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c) old age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-19-54, 19___, to 8-15-, 19 67, that I last saw the deceased alive on 8-14-67, 19___, and that death occurred at 1:00a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 457 Maurice E. Scheer MD | 23b. ADDRESS Wendell, Idaho 83355 | 23c. DATE SIGNED 8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 8-18-67 | 24c. NAME OF CEMETERY OR CREMATORY Filer Cemetery | 24d. LOCATION (City, town, or county) (State) Filer- Twin Falls Co. Ida.

DATE REC'D BY LOCAL REG. Aug 21 1967 | REGISTRAR'S SIGNATURE Louella M. Scheer | 25. EMBALMER Robert L. Meyer | LICENSE NO. E-424

FIRM NAME: Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 23 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3597
Local Reg. No. 1015
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome — LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270 b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 113 East Ave. "C"

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) 099 c. (Last) KINSFATER

4. DATE OF DEATH (Month) (Day) (Year) Aug. 17, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Nov. 25, 1886

9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Brunendahl, Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jacob Kinsfater — BIRTHPLACE Russia

14. MOTHER'S MAIDEN NAME Katherine Kinsfater (not related) — BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 42 1679

17. INFORMANT'S SIGNATURE X Robert Buhm — ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of Esophagus — INTERVAL BETWEEN ONSET AND DEATH 2 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Tracheo esophageal fistula 2 weeks.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/14, 1949, *to* 8/17, 1967, *that I last saw the deceased alive on* 8/16, 1967, *and that death occurred at* 10:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 476 J. E. Sloan (Degree or title) M.D. — **23b. ADDRESS** Jerome Idaho — **23c. DATE SIGNED** 8/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** Aug. 21, 1967 — **24c. NAME OF CEMETERY OR CREMATORY** Jerome Cemetery — **24d. LOCATION** (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. Aug. 21, 1967 — REGISTRAR'S SIGNATURE Lowella M. Scherer — **25. EMBALMER** W. L. Hove — LICENSE NO. E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3598
Local Reg. No. 1016
Reg. Dist. No. 440

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 AUG 23 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) Bureau of Vital Statistics
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Road, south of Desert Edge Country Club 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 220 West Ave. "F"

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE
b. (Middle) A.
c. (Last) MILLER

4. DATE OF DEATH (Month) (Day) (Year) Aug. 19, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Aug. 19, 1931
9. AGE (In years last birthday) 36 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hvy. Eqpt. Opr. 11
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Vernal, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME T. O. Miller — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Vera Carpenter — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) 1948 - 1952 7
16. SOCIAL SECURITY NO. 725 01 7639
17. INFORMANT'S OWN SIGNATURE Geraldine Conner — ADDRESS Jerome, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fract & multiple injuries — INTERVAL BETWEEN ONSET AND DEATH none

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 7 mi So of Jerome 14
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 270 Jerome (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 0
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Drove off edge of canyon trail.

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 11:30 a.m., from the causes and on the date stated above.*

23a. SIGNATURE H. M. Weber Cr. 583 (Degree or title) Coroner 4
23b. ADDRESS Jerome
23c. DATE SIGNED 21 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. Aug. 22 1967
REGISTRAR'S SIGNATURE Louella M. Schurer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-7851
BIRTH NO.

RECEIVED
SEP 1 1967
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3599
Local Reg. No. 1018
Reg. Dist. No. 440

1. PLACE OF DEATH
a. COUNTY: Jerome 270 4-09
b. CITY OR TOWN: Jerome
LENGTH OF STAY (in this place): 9 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 320 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Richfield
d. STREET ADDRESS (If rural, give location): Box 62

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Kenneth	Sams	Aug. 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Child	Aug. 22, 1967			9

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child-Infant 02		Jerome, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Kenneth Leroy Sams	Marshall, N. C.	Mildred Reinsch	Hailey, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Kenneth L. Sams	Richfield, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7620

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchiolar Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 9 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 22 Aug, 1967, *to* 22 Aug, 1967, *that I last saw the deceased alive on* 22 Aug, 1967, *and that death occurred at* 3:20 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. M. Heber, M.D.	385 Jerome	25 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-24-1967	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 28 1967	Louella M. Deherer	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3600
Local Reg. No. 1019
Reg. Dist. No. 440

BIRTH NO.

RECEIVED SEP 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270 3-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 078
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
d. STREET ADDRESS (If rural, give location): Croy

3. NAME OF DECEASED (Type or Print)
a. (First): HENRIETTA
b. (Middle): V. 099
c. (Last): JONES

4. DATE OF DEATH (Month) (Day) (Year): Aug. 23, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Oct. 10, 1888
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Brodford, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eli L. Vancil — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Temperance Furby — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-22-7279
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Bellevue, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

585X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Biliary cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): chronic cholecystitis — several years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 7-24-67
19b. MAJOR FINDINGS OF OPERATION: Biliary cirrhosis, multiple abscesses of liver & gall bladder
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-14, 1967, *to* 8-23, 1967, *that I last saw the deceased alive on* 8-23, 1967, *and that death occurred at* 6:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): 385
23b. ADDRESS: Box 68 - Shoshone Idaho
23c. DATE SIGNED: 8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 26. 67
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: Aug. 29 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: Keith Bird — LICENSE NO.: E 373
FIRM NAME: Bird Funeral Home, Hailey, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3601
Local Reg. No. 1017
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 900 So. Buchanan 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 900 So. Buchanan

3. NAME OF DECEASED (Type or Print)
a. (First) MAUD
b. (Middle) BELLE
c. (Last) TIPTON

4. DATE OF DEATH (Month) (Day) (Year) Aug. 24, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 13, 1908
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Billings, Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME T. L. McAdams — BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Nellie M. Clark — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 18 1570
17. INFORMANT'S OWN SIGNATURE X [signature] — ADDRESS 900 So. Buchanan Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Presumably Coronary — INTERVAL BETWEEN ONSET AND DEATH minutes only

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-18, 1967, *to* 24 Aug, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 4:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 583 (Degree or title) Coroner
23b. ADDRESS Jerome
23c. DATE SIGNED 25 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. Aug. 25, 1967
REGISTRAR'S SIGNATURE Luella M. Scherer
25. EMBALMER [signature]
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3602
Local Reg. No. 1020
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) 000
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Interstate Hwy. 80 8 mi. so. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul
d. STREET ADDRESS (If rural, give location) 409 West Lincoln

3. NAME OF DECEASED (Type or Print)
a. (First) Raymond
b. (Middle) Edward
c. (Last) Denton

4. DATE OF DEATH (Month) (Day) (Year) Aug. 27, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Aug. 28, 1947
9. AGE (In years last birthday): 19 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Jr. College
11. BIRTHPLACE (State or foreign country): Baxter Springs, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert E. Denton, BIRTHPLACE: Baxter Springs, Ka.
14. MOTHER'S MAIDEN NAME: Leta Kay Weiche, BIRTHPLACE: Berneice, Okla.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: 519 52 2786
17. INFORMANT'S OWN SIGNATURE: Robert E. Denton — ADDRESS: Paul, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8230

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple injuries — INTERVAL BETWEEN ONSET AND DEATH: 20-30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hwy 80 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 270 (STATE) Jerome Ida
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8-27-67- approx 11 p.m.
21e. INJURY OCCURRED: WHILE AT WORK ☑ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Truck left road & rolled

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 11:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title) Coroner 4
23b. ADDRESS: Jerome
23c. DATE SIGNED: 29 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 31, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Aug. 30, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3603
Local Reg. No. 1021
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 1 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome (rural)
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): InterstaeHwy.80 8 mi south 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 340
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paul I
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Myrl
b. (Middle): Scott
c. (Last): KLAMM

4. DATE OF DEATH (Month) (Day) (Year): August 27, 1967

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: June 6, 1947
9. AGE (In years last birthday): 20 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rupert, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred Klamm — BIRTHPLACE: Paul, Idaho
14. MOTHER'S MAIDEN NAME: Darlene Scott — BIRTHPLACE: Cambridge, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 52 2084
17. INFORMANT'S OWN SIGNATURE: Fred Klamm — ADDRESS: Paul Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8230

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Fractured — INTERVAL BETWEEN ONSET AND DEATH: minutes only

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT (Specify): ~~SUICIDE~~ ~~HOMICIDE~~
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 1 Hwy 80 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 270 Jerome Ida.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 27 67 approx 11:00 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Truck left road & rolled

22. *I hereby certify that I attended the deceased from* ——, 19__, *to* ——, 19__, *that I last saw the deceased alive on* ——, 19__, *and that death occurred at* 11:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: L. M. Neher, M.D. 583 (Degree or title): Coroner 4
23b. ADDRESS: Jerome
23c. DATE SIGNED: 29 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Aug. 31, 1967
24c. NAME OF CEMETERY OR CREMATORY: Paul Cemetery
24d. LOCATION (City, town, or county) (State): Paul, Idaho

DATE REC'D BY LOCAL REG.: Aug. 30, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3604
Local Reg. No. 1022
Reg. Dist. No. 440

BIRTH NO.

RECEIVED SEP 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 270
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 413 East Main

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DONALD	MARION	ALBERTS	Aug. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 6, 1908	58				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shoe Salesman 24	Retail Sales	Rockford, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Alberts	England	Emma Merkert	Not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	549 10 8820	X Gerri R. Alberts	Jerome, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhagic cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 38 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — approx. 10 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug. 27, 1967, *to* Aug. 29, 1967, *that I last saw the deceased alive on* Aug 29, 1967, *and that death occurred at* 3:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Jon D. Wilmoth, M.D. 770 (Degree or title)	216 E. Main; Jerome, Ida	Aug. 29, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 31, 1967	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 30, 1967	Louella M. Deherer	W. L. Hove	E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 13 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED SEP 5 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3605
Local Reg. No. 1023
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 000
b. CITY OR TOWN Jerome
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270 b. COUNTY Jerome
c. CITY OR TOWN Jerome
d. STREET ADDRESS (If rural, give location) 413 East Ave. "F"

3. NAME OF DECEASED (Type or Print) a. (First) Cleveland b. (Middle) Russell 099 c. (Last) Polson

4. DATE OF DEATH (Month) (Day) (Year) Aug. 30, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Oct. 19, 1882

9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Salina, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Polson BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME Margaret Irons BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 18 5409

17. INFORMANT'S OWN SIGNATURE X Mabel M. Polson ADDRESS Jerome, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 260X Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 4 yrs.
DUE TO (c) Diabetes & senility. — yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1956, *to* 30 Aug, 1967, *that I last saw the deceased alive on* 29 Aug, 1967, *and that death occurred at* 7:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE H. W. Heber M.D. 385 (Degree or title) I

23b. ADDRESS Jerome

23c. DATE SIGNED 1 Sep 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 2, 1967

24c. NAME OF CEMETERY OR CREMATORY Jerome, Cemetery

24d. LOCATION (City, town, or county) Jerome, Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 1, 1967

REGISTRAR'S SIGNATURE Louella M. Deherer

25. EMBALMER W. L. Hove

LICENSE NO. E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 0 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3606
Local Reg. No. 178
Reg. Dist. No. 120

RECEIVED SEP 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Lakes
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Lake 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Wash b. COUNTY 555 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) Rt # 4

3. NAME OF DECEASED (Type or Print) a. (First) Don b. (Middle) Lee c. (Last) Westerman

4. DATE OF DEATH (Month) (Day) (Year) July 14 1967

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1

8. DATE OF BIRTH Dec 4 1960

9. AGE (In years last birthday) 6 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Seattle Wash

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Dean E. Westerman BIRTHPLACE Unkown

14. MOTHER'S MAIDEN NAME Muriel Kingsley BIRTHPLACE Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Dean Westerman ADDRESS Spokane Wash

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 18

21c. (CITY, TOWN, OR TOWNSHIP) Twin Lakes 13 (COUNTY) 280 Kootenai (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE 583 (Degree or title) William T. Wood M.D. Coroner 4

23b. ADDRESS Coeur d'alene Idaho

23c. DATE SIGNED 9-6-'67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 18, 1967

24c. NAME OF CEMETERY OR CREMATORY Greenwood

24d. LOCATION (City, town, or county) Spokane (State) Wash

DATE REC'D BY LOCAL REG. Aug. 7, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER David D. Noland

LICENSE NO. E-493

FIRM NAME: YATES FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 22 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3607
Local Reg. No. 179
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Francis b. (Middle) Everett c. (Last) Johnson

4. DATE OF DEATH (Month) (Day) (Year) July 24, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 10-2-1915
9. AGE (In years last birthday) 51 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Parma, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Sam H. Johnson
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Adie H. Carlton
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. II 4
16. SOCIAL SECURITY NO. 532-34-9930

17. INFORMANT'S OWN SIGNATURE Marian Johnson ADDRESS Post Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suicide by Gunshot wound in Chest. — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ~~ACCIDENT~~ SUICIDE ~~HOMICIDE~~ (Specify) Suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 28 (STATE) Post Falls - Kootenai Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Shot himself w a shot gun

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 583 (Degree or title) Coroner 4
23b. ADDRESS Coeur d'Alene Idaho
23c. DATE SIGNED 9-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 7-27-1967
24c. NAME OF CEMETERY OR CREMATORY Fairmont Memorial Pk.
24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. Sept 19, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred H. Noland
LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 6 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 21 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

wood -

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3608
Local Reg. No. 144
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 280 AUG 1 1 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
c. LENGTH OF STAY (in this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Satellite Motel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Wash. b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Marysville
d. STREET ADDRESS (If rural, give location) 4115 81 St.

3. NAME OF DECEASED (Type or Print)
a. (First) Anna b. (Middle) Josephine c. (Last) Bryn

4. DATE OF DEATH (Month) August (Day) 2, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH July 5, 1891
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Florian Nigg — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Minnie Zange — BIRTHPLACE Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Amelia T. Hays, Box 157 Macdoel, Calif — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. Coroner 4 583 (Degree or title)
23b. ADDRESS Coeur d'alene Idaho
23c. DATE SIGNED 8-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-7-1967
24c. NAME OF CEMETERY OR CREMATORY Riverview Cemetery
24d. LOCATION (City, town, or county) Oroville, (State) Wash.

DATE REC'D BY LOCAL REG. Aug. 7, 1967
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER Bill Leuff
LICENSE NO. E-439

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Wm. T. Wood

Certificate of Death

RECEIVED
AUG 17 1967
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3609
Local Reg. No. 450
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 280 = KOOTENAI 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) FARRAGUT STATE PARK
c. LENGTH OF STAY (in this place) 1-DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 WASHINGTON
b. COUNTY 555 KING
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) SEATTLE
d. STREET ADDRESS (If rural, give location) 3526-N-E-182 STREET

3. NAME OF DECEASED (Type or Print)
a. (First) MARVIN
b. (Middle) C.
c. (Last) MAHLMAN

4. DATE OF DEATH (Month) (Day) (Year) AUGUST 4, 1967

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3
8. DATE OF BIRTH NOV. 29, 1910
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPTICIAN 21
10b. KIND OF BUSINESS OR INDUSTRY COLUMBIAN OPTICIAL
11. BIRTHPLACE (State or foreign country) MINNESOTA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME FRED C. MAHLMAN — BIRTHPLACE ----------
14. MOTHER'S MAIDEN NAME HATTIE ABBOTT — BIRTHPLACE ----------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 468-09-7154
17. INFORMANT'S OWN SIGNATURE MRS. PHYLLIS MAHLMAN — ADDRESS SEATTLE, Wn.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? History of previous heart trouble

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood M.D. Coroner 4 — 583 (Degree or title)
23b. ADDRESS Coeur d'alene, Idaho
23c. DATE SIGNED 8-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 3
24b. DATE 8-5-67
24c. NAME OF CEMETERY OR CREMATORY ACACIA FUNERAL HOME
24d. LOCATION (City, town, or county) SEATTLE, WASHINGTON (State)

DATE REC'D BY LOCAL REG. Aug. 15, 1967
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER N. F. Pighinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: ENGLISH CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3610
Local Reg. No. 151
Reg. Dist. No. 120

RECEIVED
AUG 17 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 000
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 281 b. COUNTY Kootenai
c. CITY OR TOWN Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Pinewood Manor

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) A. 101 c. (Last) Spencer

4. DATE OF DEATH (Month) (Day) (Year) August 4, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 30, 1877
9. AGE (In years last birthday) 90 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawfiler 14
10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill
11. BIRTHPLACE (State or foreign country) Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE ---
14. MOTHER'S MAIDEN NAME BIRTHPLACE ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-03-9665
17. INFORMANT'S OWN SIGNATURE George Costello (Rd) ADDRESS Coeur d'alene, Ida.

4201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarct, acute — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary edema
A-V. Block

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1955 19__, *to* ____, 19__, *that I last saw the deceased alive on* 8-4, 1967, *and that death occurred at* 4:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] MD 25 (Degree or title)
23b. ADDRESS Coeur D'Alene Idaho
23c. DATE SIGNED 8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-8-1967
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG. Aug. 15, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brunk
25. EMBALMER Bill Duff
LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3611
Local Reg. No.
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 280 Kootenai AUG 17 1967 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bayview Bureau of Vital Statistics
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011 b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Cecil b. (Middle) E. c. (Last) Smallwood

4. DATE OF DEATH (Month) (Day) (Year) August 6, 1967

5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3 | 8. DATE OF BIRTH May 22, 1904 | 9. AGE (In years last birthday) 63 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Corporation-Pilot | 10b. KIND OF BUSINESS OR INDUSTRY Heavy Construct | 11. BIRTHPLACE (State or foreign country) t. Watsonville, Calif. | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Eugene Smallwood | BIRTHPLACE Lancaster

14. MOTHER'S MAIDEN NAME Ethel O. Zimmek | BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | 16. SOCIAL SECURITY NO. Unobtainable

17. INFORMANT'S OWN SIGNATURE × Mrs. Cecil E. Smallwood | ADDRESS Bayview, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronaryocclusion | INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 583 (Degree or title) William T. Wood, M.D. Coron 4 | 23b. ADDRESS Coeur d'alene Idaho | 23c. DATE SIGNED 8-7-'67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3 | 24b. DATE 8-6-1967 | 24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery | 24d. LOCATION (City, town, or county) Boise, (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 16, 1967 | REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Bill Leuff | LICENSE NO. E-439

FIRM NAME: Gibson' Funeral Home, Boise

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 12 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 10 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

DEC 7 1983

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3612
Local Reg. No. 154
Reg. Dist. No. 120

RECEIVED
AUG 24 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 29 Kootenai 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: D.O.A. Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 44 Washington
b. COUNTY: 555 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): E. 1624 DeSmet

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	John	W. 000	McGillivray	August 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married 1	12-5-1901	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper 19	Boundary Dam	Athens, Wisc.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alex B. McGillivray	Unobtainable	Ida H. Hess	Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	518-05-1409	Alex McGillivray	at the home

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Acute Coronary Occlusion 4201 — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Did not ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood M.D.	583 Coroner 4	Coeur d'alene, Idaho	8-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-10-1967	Holy Cross	Spokane, Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 17 1967	Lorraine K. Brush	Thornhill Geraghty	

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: Thornhill Geraghty Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3613
Local Reg. No. 147
Reg. Dist. No. 120

Certificate of Death

RECEIVED
AUG 17 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 281 Kootenai 111
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 11 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 281
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 1002 Elm St.

3. NAME OF DECEASED (Type or Print)
a. (First) Irvin
b. (Middle) McGilll
c. (Last) Putzier

4. DATE OF DEATH (Month) (Day) (Year) August 9, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 10-15-1897
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Carl Putzier — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Harriett McGill — BIRTHPLACE Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 540-14-0233A
17. INFORMANT'S OWN SIGNATURE Mrs. Ethel Putzier — ADDRESS Coeur d' A. Id.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 da

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Bronchiogenic Carcinoma — 6 mo
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-11, 1967, *to* 8-8, 1967, *that I last saw the deceased alive on* 8-8, 1967, *and that death occurred at* 5 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Ronald Barclay MD (Degree or title) 025
23b. ADDRESS Coeur d Alene, Ida
23c. DATE SIGNED 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-12-1967
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Aug. 15, 1967
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER Fred H. Noland — LICENSE NO. E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 17 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3614
Local Reg. No. 155
Reg. Dist. No. 120

Certificate of Death

RECEIVED
AUG 24 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 281 Kootenai 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spirit Lake
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle) Gertrude
c. (Last) Murrell

4. DATE OF DEATH (Month) (Day) (Year) August 10, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 10-11-1904
9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Oregon
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE
14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 541-30-0188
17. INFORMANT'S OWN SIGNATURE Olive M. Croghan — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prob. acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive CVD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 15, 1967, *to* Aug 10, 1967, *that I last saw the deceased alive on* July 15, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE R. H. Eggleston 658 (Degree or title)
23b. ADDRESS Hayden Lake, Idaho
23c. DATE SIGNED 8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Aug 12, 1967
24c. NAME OF CEMETERY OR CREMATORY Eugene Cemetery
24d. LOCATION (City, town, or county) (State) Eugene, Oregon

DATE REC'D BY LOCAL REG. Aug. 18, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3615
Local Reg. No. 156
Reg. Dist. No. 120

Certificate of Death

RECEIVED
AUG 24 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 281 Kootenai 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location) P.O. Box 169

3. NAME OF DECEASED (Type or Print)
a. (First) Svea
b. (Middle) Sophia
c. (Last) Palo

4. DATE OF DEATH (Month) (Day) (Year) Aug. 11, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 21, 1905
9. AGE (In years last birthday) 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE X Isak W. Palo — ADDRESS Mullan

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypoproteinemia — months
DUE TO (c) Diabetes Mellitus & Kimmel Steel Wilson Disease — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
ASHD-

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION 0
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-13-67, 19__, *to* 8-11-67, *that I last saw the deceased alive on* 8-11-67, 19__, *and that death occurred at* 1205 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE John M. Lanham M.D. 622 (Degree or title)
23b. ADDRESS Hayden Lake, Idaho
23c. DATE SIGNED 8-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-15-67
24c. NAME OF CEMETERY OR CREMATORY Mullan Cemetery
24d. LOCATION (City, town, or county) Mullan, (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 21, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Dale L. Cornell
LICENSE NO. E 406

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 4 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Wood

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3616
Local Reg. No. 152
Reg. Dist. No. 120

BIRTH NO.

AUG 24 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 280 Kootenai 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
c. LENGTH OF RESIDENCE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Worley
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Fred
b. (Middle)
c. (Last) Foss

4. DATE OF DEATH (Month) Aug. (Day) 12 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH October 19, 1875
9. AGE (In years last birthday) 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work 04
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Washington
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Asle Foss — BIRTHPLACE Wisconsin
14. MOTHER'S MAIDEN NAME Ellen Jane Ames — BIRTHPLACE Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 535-24-4791
17. INFORMANT'S OWN SIGNATURE Elmer Foss (DE) — ADDRESS Brockton, Mont.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8161

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental Traumatism - auto

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) accident

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Immediate

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ HOMICIDE (Specify) accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 280 **(STATE)** Rural Worley Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car ran into back of a Truck

22. *I hereby certify that I attended the deceased from* Did not 2 *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 583 (Degree or title) Coroner 4
23b. ADDRESS Coeur d'alene Idaho
23c. DATE SIGNED 8-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 7
24b. DATE Aug. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY Worley Cemetery
24d. LOCATION (City, town, or county) (State) Worley Kootenai, Idaho

DATE REC'D BY LOCAL REG. Aug 17, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Riplinger, Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 24 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3617
Local Reg. No. 153
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur do Alene
c. LENGTH OF STAY (in this place) 36 yrs. 136
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 281
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene,
d. STREET ADDRESS (If rural, give location) 202 S. 7th. St.

3. NAME OF DECEASED (Type or Print)
a. (First) Agnes
b. (Middle) H. 101
c. (Last) Frost

4. DATE OF DEATH (Month) Aug. (Day) 13, (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 9-25-1888

9. AGE (In years last birthday) 78
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Winsted, Minn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Louis LaVallee
BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME Anna Bepo
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 534-05-6106B

17. INFORMANT'S OWN SIGNATURE Ivan Frost, Coeur d' Alen, Idaho
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of large Bowel — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Arthritis — — — 5 years

Conditions contributing to the death but not related to the disease or condition causing death.

1538

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 20, 1963, *to* Aug 13, 1967, *that I last saw the deceased alive on* Aug 13, 1967, *and that death occurred at* 7:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Rev. T. Henson, 225 (Degree or title)

23b. ADDRESS M.D. Coeur d'Alene Idaho

23c. DATE SIGNED Aug 15, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8-14-1967

24c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemt.

24d. LOCATION (City, town, or county) Coeur d Alene, Idaho (State)

DATE REC'D BY LOCAL REG. Aug. 16, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred H. Noland

LICENSE NO. E -493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Wood

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3618
Local Reg. No. 157
Reg. Dist. No. 120

BIRTH NO.

AUG 24 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 280 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 833 Grant 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location) 833 Grant

3. NAME OF DECEASED (Type or Print) a. (First) Lenna b. (Middle) G. c. (Last) Partridge

4. DATE OF DEATH (Month) (Day) (Year) August 13, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH 11-11-1897

9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jesse Evans BIRTHPLACE

14. MOTHER'S MAIDEN NAME Unobtainable Lewis BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 522-05-8307D

17. INFORMANT'S OWN SIGNATURE ADDRESS
Herbert J. Partridge DE Vista, Cali

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Didn't, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood M.D. 583 (Degree or title) Coroner 4

23b. ADDRESS Coeur d'Alene Idaho

23c. DATE SIGNED 8-15-'67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 8-14-1967

24c. NAME OF CEMETERY OR CREMATORY Thornhill Geraghty F. H.

24d. LOCATION (City, town, or county) Spokane, (State) Wash.

DATE REC'D BY LOCAL REG. Aug 17, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER N.F. Riplinger, Jr.

LICENSE NO. E-397

FIRM NAME: Thornhill Geraghty Funeral HOme- Spokane, Wash.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: SEP 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Pr 10 ... d

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3619
Local Reg. No. 162
Reg. Dist. No. 120

BIRTH NO.

SEP 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 115
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (If outside place): 15 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Coeur d' Alene Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print)
a. (First): Maude
b. (Middle):
c. (Last): Herrick

4. DATE OF DEATH (Month) (Day) (Year): August 14, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 8-6-1879
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Amboy, Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank Herrick — BIRTHPLACE: Michigan
14. MOTHER'S MAIDEN NAME: Isabel Powell — BIRTHPLACE: Trenton, N.J.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-60-8114
17. INFORMANT'S OWN SIGNATURE — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) arterio sclerosis — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1960, to 8-14, 1967, that I last saw the deceased alive on 8-1, 1967, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Wood, M.D. 572
23b. ADDRESS: Coeur d'alene Idaho
23c. DATE SIGNED: 8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-17-67
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry Bonner, Idaho

DATE REC'D BY LOCAL REG.: Aug 22, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: N.F. Riplinger Jr.
LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3620
Local Reg. No. 158
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
AUG 24 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Worley
c. LENGTH OF STAY IN THIS PLACE:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Worley
d. STREET ADDRESS (If rural, give location): Rt. I

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Veda	Orilla	Rush	August 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	12-5-1892	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William D. Eggleston	Iowa	Mary E. Luke	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	531-24-6519	X Henry Eggleston	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction - terminal — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriorsclerotic vascular disease — 3 mon.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6/8/67, 19___, *to* 8/14/67, 19___, *that I last saw the deceased alive on* 7/28/67, 19___, *and that death occurred at* 3:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
W. E. Hurd 205 (Degree or title) MD1	Fairfield, Wash	8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8-16-1967	Tekoa Cemetery	Tekoa Wash. Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 18, 1967	Lorraine K. Brush	M. A. Tuplinger Jr.	E-397

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 25 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 10 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3621
Local Reg. No. 169
Reg. Dist. No. 120

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 5 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 281 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 825 W. Garden 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 281
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 825 W. Garden

3. NAME OF DECEASED (Type or Print)
a. (First) Amy
b. (Middle) Edna
c. (Last) Warren

4. DATE OF DEATH (Month) August (Day) 15, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 8-18-1865
9. AGE (In years last birthday) 101 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own HOme
11. BIRTHPLACE (State or foreign country) Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hezehiah Vineyard — BIRTHPLACE Penn.
14. MOTHER'S MAIDEN NAME Ann Field — BIRTHPLACE unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-60-7605T
17. INFORMANT'S OWN SIGNATURE — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4222

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1966, *to* 8-15, 1967, *that I last saw the deceased alive on* 8-15, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood 572 (Degree or title) M.D.
23b. ADDRESS Coeur d' alene Idaho
23c. DATE SIGNED 8-18-'67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-19-1967
24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery
24d. LOCATION (City, town, or county) Post Falls (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 22, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Riplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d' Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 05 1996

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3622
Local Reg. No. 1622
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY 28 Kootenai — SEP 5 1967 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene — c. LENGTH OF STAY IN (Hospital) 5 days — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE Idaho — b. COUNTY 28 Kootenai — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene — d. STREET ADDRESS (If rural, give location) 1209 Mullan

3. NAME OF DECEASED (Type or Print) — a. (First) Charles — b. (Middle) J. — c. (Last) Menard

4. DATE OF DEATH — (Month) August — (Day) 16, — (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: 3-18-1885

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attendant

10b. KIND OF BUSINESS OR INDUSTRY: Eagles Lodge

11. BIRTHPLACE (State or foreign country): Minn.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Menard — BIRTHPLACE: Unobtainable

14. MOTHER'S MAIDEN NAME: Mary (obtainable) — BIRTHPLACE: Obtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO. 539-07-0103

17. INFORMANT'S OWN SIGNATURE: Mrs. [illegible] Moreau — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic cardio-vasc. disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Emphysema — 6 yr.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21, 1967, *to* 8-16, 1967, *that I last saw the deceased alive on* 8-15, 1967, *and that death occurred at* 1:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): Frank Barclay MD — 23b. ADDRESS: Coeur d Alene Ida — 23c. DATE SIGNED: 8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 8-19-1967 — 24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery — 24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.: Aug 22 1967 — REGISTRAR'S SIGNATURE: Lorraine K. Brewer

25. EMBALMER: N.F. Riplinger Jr. — LICENSE NO.: E-397

FIRM NAME: English Chapel-Coeur d' Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3623
Local Reg. No. 159
Reg. Dist. No. 120

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

SEP 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 281 Kootenai 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene

c. LENGTH OF STAY (In hospital)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1219 Mill Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 281 b. COUNTY Kootenai

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene

d. STREET ADDRESS (If rural, give location) 1219 Mill Ave.

3. NAME OF DECEASED (Type or Print)

a. (First) Raymond b. (Middle) A. c. (Last) Adams

4. DATE OF DEATH (Month) (Day) (Year) Aug. 17, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1

8. DATE OF BIRTH 4-7-1965

9. AGE (In years last birthday) 2 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Edward J. BIRTHPLACE St. Maries, Ida.

14. MOTHER'S MAIDEN NAME Donna Whitehead BIRTHPLACE Moscow, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Edward J. Adams ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Conflagration - Burning of home — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 280 **(STATE)** Coeur d'Alene Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? House caught fire - trapped upstairs

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D. 572 (Degree or title) 1

23b. ADDRESS Coeur d'Alene Idaho

23c. DATE SIGNED 8-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1

24b. DATE August 24, 67

24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery

24d. LOCATION (City, town, or county) (State) St. Maries Benewah, Idaho

DATE REC'D BY LOCAL REG. Aug. 22, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER N. F. Replinger Jr. **LICENSE NO.** E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3624
Local Reg. No. 168
Reg. Dist. No. 12 c

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 28 Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place) 000 48
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 01

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington
b. COUNTY 55 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) North 5004 Lincoln Street

3. NAME OF DECEASED (Type or Print)
a. (First) Roy
b. (Middle) C.
c. (Last) Seaver

4. DATE OF DEATH (Month) (Day) (Year) August 18, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 11/18/1896

9. AGE (In years last birthday) 70 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Paper Maker 2

10b. KIND OF BUSINESS OR INDUSTRY Inland Empire Paper Co.

11. BIRTHPLACE (State or foreign country) Sprague, Washington

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Daniel M. Seaver
BIRTHPLACE Unobtainable

14. MOTHER'S MAIDEN NAME Mollie E. Snyder
BIRTHPLACE Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) World War One 3

16. SOCIAL SECURITY NO. 533-03-4889

17. INFORMANT'S OWN SIGNATURE Hazel V Seaver
ADDRESS Mrs. 5004 Lincoln St. Spokane, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Probable myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 1-2 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 18, 1967, *to* Aug 18, 1967, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* about 9:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE W. Wray Wilson MD 568 (Degree or title)

23b. ADDRESS Coeur d'Alene, Idaho

23c. DATE SIGNED 8/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2

24b. DATE 8/21/1967

24c. NAME OF CEMETERY OR CREMATORY Hazen & Jaeger Crematory

24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. Aug 28, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Hazen&Jaeger Funeral Chapel
LICENSE NO.

FIRM NAME: Hazen&Jaeger Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3625
Local Reg. No. 167
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 288
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lower Twin Lake 000
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lower Twin Lake 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Spokane 063
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) W 4808 Princeton Place

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Donald	Edward	Poffenroth	Aug. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	11-2-1963	3				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child 02	None	Spokane, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert R. Poffenroth	Unobtainable	x Rita Knapp	Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		x Robert R Poffenroth	W4808 Princeton P.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Accidental Drowning. — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident	Down Twin Lake 18	13	288 Kootenai,	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		Fell off of a Dock

22. *I hereby certify that I attended the deceased from* Did Not, 19___, to _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood	583 M.D.	Coeur d'alene Idaho	8-25-'67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8-19-1967	Hazen-Jaeger	Spokane Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 28 1967	Lorraine K. Brush	Bill Duff	E-439

FIRM NAME: English Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3626
Local Reg. No. 163
Reg. Dist. No. 120

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 28/ Kootenai — SEP 5 1967 — 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp.

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location) Rt. #2, Box 132

3. NAME OF DECEASED (Type or Print)
a. (First) Leo
b. (Middle) 101
c. (Last) Larson

4. DATE OF DEATH (Month) (Day) (Year) Aug. 21, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH 1-18-1891

9. AGE (In years last birthday) 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lewis Larson
BIRTHPLACE U.S.A.

14. MOTHER'S MAIDEN NAME Susie Merick
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs. H.D. Collins
ADDRESS Post Fls. Idaho

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardio Vascular Disease — Chronic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arthritis — Chronic

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1961, 19__, *to* 8/21/67, 19__, *that I last saw the deceased alive on* 8/21/67, 19__, *and that death occurred at* 8:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Lynn C Erickson MD (Degree or title)

23b. ADDRESS Coeur d'Alene, Idaho.

23c. DATE SIGNED 8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8-25-1967

24c. NAME OF CEMETERY OR CREMATORY Evergreen Cemetery

24d. LOCATION (City, town, or county) (State) Post Falls, Idaho

DATE REC'D BY LOCAL REG. Aug 28 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3627
Local Reg. No. 166
Reg. Dist. No. 120

RECEIVED

Certificate of Death

STATE OF IDAHO

SEP 5 1967

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 28/ Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION Pinewood Manor 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28/
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Rt. # 1, Box 349

3. NAME OF DECEASED (Type or Print) a. (First) Frederick b. (Middle) c. (Last) Mjelde

4. DATE OF DEATH (Month) (Day) (Year) Aug. 21, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 2-8-1891

9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oil Distributer 21

10b. KIND OF BUSINESS OR INDUSTRY retired

11. BIRTHPLACE (State or foreign country) Big Timber, Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ben Mjelde BIRTHPLACE Wisc.

14. MOTHER'S MAIDEN NAME Louisa S. Klibasdale BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 516-54-7860A

17. INFORMANT'S OWN SIGNATURE ADDRESS Julia Mjelde, Coeur d' Alene, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

203X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cachexia — INTERVAL BETWEEN ONSET AND DEATH: Weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Adenocarcinoma, prostate, metastatic

DUE TO (c) Multiple myeloma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis
Hypertensive cardiovascular disease

19a. DATE OF OPERATION —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 July, 1967, *to* 21 Aug, 1967, *that I last saw the deceased alive on* 21 Aug, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE 786 (Degree or title) M.D.

23b. ADDRESS 411 Coeur d'Alene Ave Coeur d'Alene Idaho

23c. DATE SIGNED 22 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 8-25-67

24c. NAME OF CEMETERY OR CREMATORY RESTLAWN CEMETERY

24d. LOCATION (City, town, or county) (State) COEUR d'ALENE, IDAHO

DATE REC'D BY LOCAL REG. Aug. 25, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3628
Local Reg. No. 1164
Reg. Dist. No. 126

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — SEP 5 1967
a. COUNTY 28 Kootenai 112
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene | LENGTH OF STAY (in this place) 12 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28 b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Coeurd Alene, Homes

3. NAME OF DECEASED (Type or Print) a. (First) Hans b. (Middle) Raymond c. (Last) Matson

4. DATE OF DEATH (Month) (Day) (Year) Aug. 23, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH 5-25-1900

9. AGE (In years last birthday) 66 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Sagola, Michigan

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Matt Matson | BIRTHPLACE Norway

14. MOTHER'S MAIDEN NAME Sina Peterson | BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-42-5382

17. INFORMANT'S OWN SIGNATURE Mrs. Edna Olsen | ADDRESS Coeurd' Alene, Id.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4938

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) aspiration

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Parkinsonism

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 52, *to* Aug 23, 1967, *that I last saw the deceased alive on* Aug 23, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 192 (Degree or title) | 23b. ADDRESS 502 a 5th | 23c. DATE SIGNED 25 Aug.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE 8-26-1978 | 24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery | 24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Aug. 28 1967 | REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred H. Noland | LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 3 0 1999

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3629
Local Reg. No. 167
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor Nursing H.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 281
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) ORREA
b. (Middle) 261
c. (Last) GAULTNEY

4. DATE OF DEATH (Month) (Day) (Year) Aug. 25, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Apr. 29, 1881
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Indiana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Weaver — BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME Delphia Secrest — BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs. Helen McCuaig (BW) — ADDRESS 718-N-8th St Coeur d' Alene, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocard. infarction — INTERVAL BETWEEN ONSET AND DEATH 24 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-24, 1967, *to* 8-25, 1967, *that I last saw the deceased alive on* 8-24, 1967, *and that death occurred at* 6 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Hazel Barclay 025 (Degree or title) MD
23b. ADDRESS Coeur d Alene
23c. DATE SIGNED 8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 28, 67
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Aug. 30, 1967
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER M. F. Ripling er Jr.
LICENSE NO. E-297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel

APR 22 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 0 6 1991

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3630
Local Reg. No. 194
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY (28) Kootenai (302)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho (280) b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location) Don Trailer Court

3. NAME OF DECEASED (Type or Print) a. (First) Howard b. (Middle) Charles (101) c. (Last) McGinley

4. DATE OF DEATH (Month) August (Day) 26, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married (3)

8. DATE OF BIRTH 4-17-1878

9. AGE (In years last birthday) 89 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher (12)

10b. KIND OF BUSINESS OR INDUSTRY Public Schools

11. BIRTHPLACE (State or foreign country) Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Parkson McGinley BIRTHPLACE Indiana

14. MOTHER'S MAIDEN NAME Alice Kuhn BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-34-5406

17. INFORMANT'S OWN SIGNATURE Mrs Faith E. Bailey ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Metastatic Carcinoma Esophagus — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma Stomach — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION October 26, 1966

19b. MAJOR FINDINGS OF OPERATION Carcinoma Stomach

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 9, 1967, *to* August 21, 1967, *that I last saw the deceased alive on* August 26, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE C. E. Thompson (530) (Degree or title) MD 1

23b. ADDRESS Coeur d Alene Idaho.

23c. DATE SIGNED August 29, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation (2)

24b. DATE 8-30-67

24c. NAME OF CEMETERY OR CREMATORY Moons Funeral HOme

24d. LOCATION (City, town, or county) Sandpoint, (State) Idaho

DATE REC'D BY LOCAL REG. Aug. 30, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER D. F. Ryplinger M.

LICENSE NO. E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 22 1967

JUL 7 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3631
Local Reg. No. 160
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 280 Kootenai — SEP 5 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bayview — Bureau of Vital Statistics
c. LENGTH OF [illegible] (If outside place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington — b. COUNTY 555 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 3831 E. 16th

3. NAME OF DECEASED (Type or Print)
a. (First) Anton — b. (Middle) Olson — c. (Last) Brende

4. DATE OF DEATH (Month) (Day) (Year) August 27, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 22, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinery Dealer 22
10b. KIND OF BUSINESS OR INDUSTRY: Farm Equipt.
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Not Obtainable — BIRTHPLACE: ------
14. MOTHER'S MAIDEN NAME: Not Obtainable — BIRTHPLACE: --------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Otis A. Brende — ADDRESS: Spokane, Wash

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

976X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suicide by Gunshot — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Wound in left Chest
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ~~ACCIDENT~~ SUICIDE ~~HOMICIDE~~ (Specify): Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 280 (STATE): Bayview Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? 2 Shot himself in chest c̄ pistol.

22. *I hereby certify that I attended the deceased from* Did not, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: William T. Wood, M.D. — 583 (Degree or title) Coroner. 4
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED: 8-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 8-29-67
24c. NAME OF CEMETERY OR CREMATORY: Holland & Bonine F.H.
24d. LOCATION (City, town, or county) (State): Havre, Montana

DATE REC'D BY LOCAL REG.: Aug 30, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: N. F. Riplinger, Jr.
LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Holland-Bonine-Havre, MOntana

DUTIES:

SEP 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 8 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3632
Local Reg. No. 3782
Reg. Dist. No. 120

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 28/ Kootenai 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Gust	Robert	Anderson		8	29	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married 3	12-10-1883	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 84
10b. KIND OF BUSINESS OR INDUSTRY Slef
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unkown — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Unkown — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518 03 3571
17. INFORMANT'S OWN SIGNATURE Mrs. Melvina Anderson — ADDRESS Post Falls Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5400

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gastric hemorrhage 24 hrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic cardiovasculardis.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-29-67	Multiple bleeding gastric ulcers	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 2:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
C. J. Cederburg M.D. (Degree or title)	Hayden Lake Medical Clinic Hayden Lake, Idaho	9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-2-67	EVERGREEN CEMETERY	POST FALLS, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 7, 1967	Lorraine K. Brueh	Gilbert Yates	E-365

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

407

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3633
Local Reg. No. 176
Reg. Dist. No. 120

BIRTH NO.

SEP 11 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Kootenai 281 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 281

b. COUNTY: Kootenai

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene

d. STREET ADDRESS (If rural, give location): 1407 N. 6th St.

3. NAME OF DECEASED (Type or Print)

a. (First): Milton

b. (Middle): E. 101

c. (Last): Thorn

4. DATE OF DEATH (Month) (Day) (Year): August 29, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 1-8-1888

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Woodsworker 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Clintonville, Wisc.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Thorn — BIRTHPLACE: -----

14. MOTHER'S MAIDEN NAME: Eugenia — BIRTHPLACE: -------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-16-9296

17. INFORMANT'S OWN SIGNATURE (B.D.): Mrs. L.V. Benjamin — ADDRESS: Coeur d'Alene, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

157X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinomia of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Carcinomia of Pancreas

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* 8/29, 1967, *that I last saw the deceased alive on* 8/29, 1967 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 174 Fox M.D.

23b. ADDRESS: Coeur d'Alene

23c. DATE SIGNED: 9/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-2-1967

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Aug 30, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: N. F. Riplinger, Jr.

LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel-Coeur d' Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Dr Henson

RECEIVED SEP 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3634
Local Reg. No. 173
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene — c. LENGTH OF STAY (in this place) 22 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28 — b. COUNTY Kootenai — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene — d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
James	Wesley	Jackson	August 31, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	June 1, 1885	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 27	Building	Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Jackson	------	Alta Almon	-----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (RD)	ADDRESS
No	None	519-03-6772	Mrs. Audrey Grisby	Coeur d'Alene, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Diabetes Mellitus	10 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetic Ulcer foot.	2 mo
	Cerebral Arteriosclerosis	5 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov., 1962, *to* Aug 31, 1967, *that I last saw the deceased alive on* Aug 31, 1967, *and that death occurred at* 12:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Rex Henson	225 M.D.	Coeur d'Alene, Idaho	Sept 6, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	9-2-1967	Forest Cemetery	Coeur d'Alene	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 11, 1967	Lorraine K. Brush	Bill Neff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3035
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291 147
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 47 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 510 East 6th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 291
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 510 East 6th

3. NAME OF DECEASED (Type or Print)
a. (First) Frances
b. (Middle) Adeline
c. (Last) MacVean

4. DATE OF DEATH (Month) August (Day) 1, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH October 22, 1913
9. AGE (In years last birthday) 53 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Book Keeper 79
10b. KIND OF BUSINESS OR INDUSTRY Dept. Store
11. BIRTHPLACE (State or foreign country) Deer Park, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Allen G. Snook — BIRTHPLACE St. Ottawa, Illinois
14. MOTHER'S MAIDEN NAME Mertie E. Studebaker — BIRTHPLACE Lewisburg, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-12-0863
17. INFORMANT'S OWN SIGNATURE Camas, Wn. ADDRESS Mona MacVean Schumacher

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4341

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH hrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Acute Congestive Heart Failure — hrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Cirrhosis of Liver — yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Night of Aug. 1 *to* 1967, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m. from the causes and on the date stated above.*

23a. SIGNATURE Chas Brooks MD. 583 (Degree or title) Co. Coroner 4
23b. ADDRESS Moscow Idaho
23c. DATE SIGNED Aug. 7 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2
24b. DATE August 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Hazen & Jaeger Crematory
24d. LOCATION (City, town, or county) Spokane, (State) Washington

DATE REC'D BY LOCAL REG. 8-14-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER Donald Ward
LICENSE NO. E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3686
Local Reg. No. 200
Reg. Dist. No.

RECEIVED AUG 15 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 29 Latah
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Moscow
c. LENGTH OF STAY (in this place) 87 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 29
b. COUNTY Latah
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Moscow
d. STREET ADDRESS (If rural, give location) 724 E. 1st

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Helen	Margaret	Rodner	August 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER A DAY Hours	Min.
Female	White	Never Married	December 11, 1886	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Millinery 25	Dept. Store	Aurora, Illinois	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
D. Rodner	Germany	Mary L. Ersch	France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		537-20-5952-A	Jacob Rodner	Fresno, Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the ovary — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Abdominal metastases — 1 year

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home; farm; factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-8, 1960 *to* 8-1, 1967, *that I last saw the deceased alive on* 8-1, 1967, *and that death occurred at* 12:35 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE		23b. ADDRESS	23c. DATE SIGNED
Edsel M. Dunn	149 (Degree or title)	Moscow Idaho	8-3-1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 3, 1967	Moscow, Cemetery	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-14-67	Cheryl Ann Williams	Donald Ward	E-380

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 19 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 20037
Local Reg. No. 200
Reg. Dist. No.

RECEIVED AUG 23 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 29 Latah 205
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 137 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 290 b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Genesee Rt.
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Rube	J.	Nelson	August 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	January 11, 1881	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Taylor Nelson — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Mary Wade — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-40-8429-A
17. INFORMANT'S OWN SIGNATURE X Edythe M. Wallen ADDRESS Moscow, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) carcinoma of pancreas — INTERVAL BETWEEN ONSET AND DEATH: six months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) | **21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | **21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | **21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* _____, 1958, to August 4, 1967, *that I last saw the deceased alive on* August 1, 1967, *and that death occurred at* 11:55 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) W. P. Marineau, M. D. | **23b. ADDRESS** 129 West 3rd, Moscow | **23c. DATE SIGNED** 8/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 4, 67	Moscow Cemetery	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-18-67	Cheryl Ann Williams	Donald Ward	E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3638
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 23 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 291 Latah 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latah County Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 290
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
d. STREET ADDRESS (If rural, give location) 10 Miles North Of Potlatch

3. NAME OF DECEASED (Type or Print)
a. (First) MICHAEL
b. (Middle) WILLIAM
c. (Last) DWART

4. DATE OF DEATH (Month) (Day) (Year) Aug. 9, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 2-10-1890
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Madera, California
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME Michael Dwart — BIRTHPLACE France
14. MOTHER'S MAIDEN NAME Incarnacion Lavornia — BIRTHPLACE California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 558-09-8361
17. INFORMANT'S OWN SIGNATURE Dorothy Kapenberger — ADDRESS Potlatch, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis — Vital Exhaustion

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Metastatic Carcinoma from Carcinoma of Colon
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Normocytic Anemia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) — m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 4-13-, 1953, *to* 8-9-, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 830 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Joseph E. Wilson MD 567 (Degree or title)
23b. ADDRESS Moscow, Idaho
23c. DATE SIGNED 8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-12-1967
24c. NAME OF CEMETERY OR CREMATORY Freeze Cemetery
24d. LOCATION (City, town, or county) (State) Latah County, Idaho

DATE REC'D BY LOCAL REG. 8-18-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER H. E. Kimball
LICENSE NO. E269

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Kimball Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 103639
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 29 Latah 105
b. CITY OR TOWN Moscow
c. LENGTH OF STAY (in this place) 4 yr. 8 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION Latah Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 29
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow, Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Maude	M.	Benton	August 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 3	June 24, 1892	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Moscow, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Hobart	Cottage Grove, Oregon	Mary Daniels	Moscow, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		534-28-7803	Geael Hobart	1026 S. Logan Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Pyelonephritis + Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 2-3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 25, 19 62 *to* August 14, 1962, *that I last saw the deceased alive on* Aug. 13, 1967, *and that death occurred at* 8:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward L. Baas MD	Professional Bldg. Moscow Ida	8-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	August 16, 67	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-26-67	Cheryl Ann Williams	Donald Ward	E-30

Federal Security Agency
U.S. Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3640 06
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 291 Latah 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 291
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 1220 Highland Dr.

3. NAME OF DECEASED (Type or Print)
a. (First) Harry
b. (Middle) N
c. (Last) Conner

4. DATE OF DEATH (Month) August (Day) 15 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 5, 1887
9. AGE (In years last birthday) 80 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber 21
10b. KIND OF BUSINESS OR INDUSTRY Moscow Barber Shop
11. BIRTHPLACE (State or foreign country) Montezuma, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gideon B. Conner — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Mary O. Smith — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-07-0467-A
17. INFORMANT'S OWN SIGNATURE Mrs H. N. Conner — ADDRESS Moscow, Ida.

4201

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac rupture — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Large coronary occlusion — 2½ days
DUE TO (c) Arteriosclerosis and age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Doyle M Lively 310 (Degree or title)
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 18, 1967
24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery
24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. 8-26-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER Donald Ward
LICENSE NO. E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 17 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 364107
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED AUG 29 1967 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY 29 Latah
b. CITY OR TOWN Moscow
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 29 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
d. STREET ADDRESS (If rural, give location) 112

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	Ida	Josephine	Milton

4. DATE OF DEATH: (Month) Aug (Day) 16 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	widowed 2	March 4, 1881	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		Sweden	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Carl Dahlen	Sweden	Anna Dahlen	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-56-1343	Rudolph Smith	Troy, Ida.

18. CAUSE OF DEATH 794X

MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Complication of age.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1950, 19__, *to* 8-16-, 19 67, *that I last saw the deceased alive on* 8-16-67, 19__, *and that death occurred at* AM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Omer A Drury	149 MD-1	Troy, Idaho 83871	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 19, 1967	Burnt Ridge Cemetery	near Troy Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-26-67	Cheryl Ann Williams	Ronald Ward	E-30

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3642 109
Local Reg. No. 200
Reg. Dist. No.

RECEIVED SEP 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 29 Latah 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 1 yr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Paradise Villa Nursing Home 339

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 290 b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Deary
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
John	Leroy	Phayer	Aug	17	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	never married	June 21, 1883	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04		Missoula, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John L. Phayer	Penn.	Emmaline Crocker	Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-64-0499	Fred Gladen	Kendrick, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	INTERVAL BETWEEN ONSET AND DEATH
	Cerebral Vascular Accident	1 day
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.	DUE TO (b) ~~Arteriosclerosis of Prostate~~	
	DUE TO (c) ~~Severe Congestive Heart Failure~~	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Severe Congestive Heart Failure	4-5 years

337X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Aug 17, 1967, *that I last saw the deceased alive on* Aug 16, 1967, *and that death occurred at* 6:00 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward L Bass MD	Professional Bldg. Moscow	8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 21, 1967	Wild Rose Cemetery	near Kendrick Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-1-67	Cheryl Ann Williams	Donald Ward	E-80

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 21 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3643 108
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 29 / Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 1/2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 29
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 512 So. Lincoln

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Florence	May	McGough	August	18,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Married 3	Feb. 22, 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Harrington, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George M. Witt	Tennessee	Alma Kalis	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-36-1629	X Francis M. McGough	Moses Lake, Wn

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Gram negative Septicemia (Suspected) — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cerebro vascular Arteriosclerosis — 10 years

DUE TO (c) Diabetes Mellitis — 1 yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8/17, 1967, *to* 8/18, 1967, *that I last saw the deceased alive on* 8/17, 1967, *and that death occurred at* 4:05 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Rodger Hawkins MD	213 N Main, Moscow	8/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 21, 1967	Moscow Catholic Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-67	Cheryl Ann Williams	Donald Ward	E-380

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 29 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3644 111
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 291 Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 4 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 290
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Juliaetta
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) RALPH
c. (Last) CORKILL

4. DATE OF DEATH (Month) (Day) (Year) 24 August 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 27 Sept 1886
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer/Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY Stock & Grain
11. BIRTHPLACE (State or foreign country) Isle of Man, England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Corkill — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Anna Corris — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 40 8068A
17. INFORMANT'S OWN SIGNATURE Wilbur Corkill — ADDRESS Kendrick, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1538 Carcinoma of Colon and Stomach with fistula and Starvation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c) Cardiac Failure

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hypertension

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-7-1967, *to* 8-24-1967, *that I last saw the deceased alive on* 8-24-1967, *and that death occurred at* 5:45 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE Joseph A. Wilson M.D. 567 (Degree or title)
23b. ADDRESS Moscow, Idaho
23c. DATE SIGNED 8-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 28 Aug 1967
24c. NAME OF CEMETERY OR CREMATORY Kendrick City Cemetery
24d. LOCATION (City, town, or county) (State) Kendrick, Idaho

DATE REC'D BY LOCAL REG. 9-1-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 113645
Local Reg. No. 200
Reg. Dist. No.

RECEIVED SEP 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 29 Latah 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 7 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latah County Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 29 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Potlatch
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAMES		MILTON	Aug. 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	8-12-1873	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wheat Farmer 04	Self	Scotland	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Victor M. Anderson	Potlatch Ida

1993

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of ear (mastoid) with direct extension of Tumor — INTERVAL BETWEEN ONSET AND DEATH 2-3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 1, 1967, *to* Aug 24, 1967, *that I last saw the deceased alive on* Aug 22, 1967, *and that death occurred at* 5:45 AM., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward L Doan	MD.	Professional Bldg. Moscow	8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-28-1967	Greenwood Cemetery	Palouse, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-1-67	Cheryl Ann Williams	H E Kimball	E269

FIRM NAME: Kimball Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3646 112
Local Reg. No. 200
Reg. Dist. No.

RECEIVED SEP 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 29 Latah 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
STAY (in this place) 2 Yr. 10 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latah County Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 29 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Potlatch
d. STREET ADDRESS (If rural, give location) 210 Spruce

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	FRANK	ELMER	HARPHAM	Aug. 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	8-25-1885	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fisherman 04	Commercial	St. Croix, Co., Wisoonsin	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Clarence J. Harpham	N. Y.	Elmira Burns	Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		574-05-0333	Ruth L. Udinder	Potlatch, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Septicemia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1, 1967 *to* Aug 25, 1967, *that I last saw the deceased alive on* Aug 25, 1967, *and that death occurred at* 8:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward L Boas MD.	Professional Bldg. Moscow	8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-29-1967	Fraternal Cemetery	Palouse, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-1-67	Cheryl Ann Williams	R E Kimball	E269

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Kimball Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 1 1 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 113647
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 5 yr. 7 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latah Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) Martha b. (Middle) Amanda c. (Last) VanDeWalker

4. DATE OF DEATH: (Month) August (Day) 27, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Dec. 28, 1884

9. AGE (In years last birthday): 83
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Cook 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-09-5722

17. INFORMANT'S OWN SIGNATURE: x Ole Sather
ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

491X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. cerebral arteriosclerosis — several yea

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 62, *to* Aug 27, 19 67, *that I last saw the deceased alive on* Aug 21 1967, *and that death occurred at* 7:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. E. Marineau, M. D.
23b. ADDRESS: 129 West 3rd, Moscow, Idah
23c. DATE SIGNED: 8/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 8 Sept. 1967
REGISTRAR'S SIGNATURE: Cheryl Ann Williams

25. EMBALMER: May J. Malutta
LICENSE NO.: E-519
FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3648 114
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 29 Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 12 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1221 Joseph St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555 Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dayton
d. STREET ADDRESS (If rural, give location) 329 W. Main

3. NAME OF DECEASED (Type or Print) a. (First) Harold b. (Middle) L c. (Last) Ebert

4. DATE OF DEATH (Month) (Day) (Year) August 30 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH August 22, 1906

9. AGE (In years last birthday) 61 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Motel Owner 22

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Mott, North Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Ebert BIRTHPLACE Campbellsport, Wisc.

14. MOTHER'S MAIDEN NAME Mary Sheilcher BIRTHPLACE Kalesville, Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 536-05-5346

17. INFORMANT'S OWN SIGNATURE Howard R Ebert ADDRESS Moscow, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4281

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis, Sudden — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Dis — yes

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 30 1967 *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE M.D. Brooks 583 (Degree or title) **23b. ADDRESS** M.D. Coroner Moscow Idaho **23c. DATE SIGNED** Sept. 6, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** Sept. 2, 1967 **24c. NAME OF CEMETERY OR CREMATORY** Vineland Cemetery **24d. LOCATION** (City, town, or county) Clarkston (State) Washington

DATE REC'D BY LOCAL REG. 9-8-67 REGISTRAR'S SIGNATURE Cheryl Ann Williams **25. EMBALMER** Mat J. Malutta LICENSE NO. E-519

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3649
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

RECEIVED SEP 7 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Lemhi 306 109
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
LENGTH OF STAY (in this place) 9 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 300
b. COUNTY Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
James	Holden	Edie	8	8	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Dec. 18, 1903	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Medicine Lodge, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George B. Edie	Scotland	Emma L. Holden	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-40-2976	Melba Edie	Salmon, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5827 Emphesema Chronic — INTERVAL BETWEEN ONSET AND DEATH 5yr+

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* death 19__, *that I last saw the deceased alive on* 8-7, 1967, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
M.D. 045 (Degree or title)	Salmon Ida	8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-11-67	Dubois Cemetery	Dubois, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-2-1967	Viola E. Johnson	Delbert C. Jones	E369

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 26 1963

MAY 17 1968

FEB 7 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3650
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

RECEIVED
SEP 7 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Salmon, Idaho
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Firth
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First): Claudine
b. (Middle): O
c. (Last): Howell

4. DATE OF DEATH (Month) 8 (Day) 11 (Year) 67

5. SEX: Female
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 16, 1896 Dec. 23, 1923
9. AGE (In years last birthday): 71
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Richmond, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Olsen
BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Mildred Traveller
BIRTHPLACE: Richmond, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Max Howell
ADDRESS: Firth Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Diabetes Mellitus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-5, 1967, *to* 8-9, 1967, *that I last saw the deceased alive on* 8-9, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. M. Withers, M.D. 569 1
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: 8-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/15/67
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery Shelley Cemetery
24d. LOCATION (City, town, or county) (State): Shelley Bingham Idaho

DATE REC'D BY LOCAL REG.: 9-2nd 67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: L. M. Nalder
LICENSE NO.: 6275

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Nalder's Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3651
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

RECEIVED SEP 7 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial Hospital 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 300
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Clarence
b. (Middle): McKinley
c. (Last): Mann

4. DATE OF DEATH (Month) 8 (Day) 13 (Year) 67

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: April 21, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kankakee, Illinois
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Warren L. Mann — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Marilla Jane Stevens — BIRTHPLACE: Illinois
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Ardella E. Mann — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 331X Hypertensive Cerebrovasc — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Disease c̄ repeated
DUE TO (c) Cerebral Hemorrhages 2 mos

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1949 *19*__ *to* __, *19*__, *that I last saw the deceased alive on* 8-13, *19*67, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: A. Marshall M.D. 045 (Degree or title)
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Salmon Cemetery
24d. LOCATION (City, town, or county): Salmon (State): Idaho

DATE REC'D BY LOCAL REG.: 9-2nd 67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3652
Local Reg. No. 698
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 7 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY 300 Lemhi 182	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Idaho 300 b. COUNTY Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon c. LENGTH OF STAY (in this place) 82 yrs.	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First) Cora Edna	b. (Middle)	c. (Last) Bowen	4. DATE OF DEATH (Month) (Day) (Year) Aug. 20, 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2	8. DATE OF BIRTH Jan. 11, 1882	9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home 01	10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Ogden, Utah	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME John Preston	BIRTHPLACE England		14. MOTHER'S MAIDEN NAME Cynthia Vowell	BIRTHPLACE Kentucky
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-18-6270		17. INFORMANT'S OWN SIGNATURE Helen B. Ling	ADDRESS Salmon, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardiovascular disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1967, *to* 8-20, 1967, *that I last saw the deceased alive on* 8-19, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 263 (Degree or title)	23b. ADDRESS Salmon Idaho	23c. DATE SIGNED 8-22-67	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE 8-22-67	24c. NAME OF CEMETERY OR CREMATORY Salmon	24d. LOCATION (City, town, or county) (State) Salmon, Idaho
DATE REC'D BY LOCAL REG. 9-2nd 67	REGISTRAR'S SIGNATURE Viola E. Johnson	25. EMBALMER Delbert C. Jones	LICENSE NO. E 369

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3653
Local Reg. No. 690
Reg. Dist. No.

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 300 Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
LENGTH OF STAY (in this place) 25 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 300 Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Ivan
b. (Middle) Vanta
c. (Last) Reddington

4. DATE OF DEATH (Month) (Day) (Year) Aug. 29, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Jan. 4, 1912

9. AGE (In years last birthday) 55
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) bar tender 23

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Leadore, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John B. Reddington
BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Cora Ellen Shelley
BIRTHPLACE Junction, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) WW 2
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-09-1313

17. INFORMANT'S OWN SIGNATURE Maud E. Reddington
ADDRESS Salmon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 5501 Appendicitis — INTERVAL BETWEEN ONSET AND DEATH 8 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Peritonitis resulting
DUE TO (c) from ruptured appendix

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary artery disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-26, 19 67, *to* 8-29, 19 67, *that I last saw the deceased alive on* 8-29, 19 67, *and that death occurred at* ____ m. *from the causes and on the date stated above.*

23a. SIGNATURE 263 (Degree or title)

23b. ADDRESS Salmon Idaho

23c. DATE SIGNED 9-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-2-67

24c. NAME OF CEMETERY OR CREMATORY Salmon

24d. LOCATION (City, town, or county) Salmon Idaho (State)

DATE REC'D BY LOCAL REG. 9-9-67

REGISTRAR'S SIGNATURE Viola E. Johnson

25. EMBALMER Delbert C. Jones

LICENSE NO. E 369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3654
Local Reg. No. 690
Reg. Dist. No.

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 300 Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
c. LENGTH OF STAY (in this place) 80 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Steele Memorial - 1 week

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 300 Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Leonard	Elvin	Stokes	Aug. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 23, 1908	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
businessman & rancher	04	Tremonton, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Heber Stokes	Utah	Mary Frances Anderson	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-40-3771	Kate Stokes	Salmon, Idaho

MEDICAL CERTIFICATION

4201

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion with massive — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) myocardial infarction
DUE TO (c) Arterio sclerotic ? Cardio Vasc disease ? Diabetes

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1949, 19____, *to* death, *that I last saw the deceased alive on* 8-29-67, 19____, *and that death occurred at* 11:42 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
045	Salmon, Idaho	8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-1-67	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-9-67	Viola E. Johnson	Gilbert C. Jones	E 369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3655
Local Reg. No. 649
Reg. Dist. No. 430

BIRTH NO.

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 320 Lincoln 100
b. CITY OR TOWN Shoshone
c. LENGTH OF STAY (in this place) yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 320 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) LOUIE b. (Middle) LAWRENCE c. (Last) MAGOFFIN

4. DATE OF DEATH (Month) Aug. (Day) 14, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 18, 1897
9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months 5 Days 26 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29
10b. KIND OF BUSINESS OR INDUSTRY ---
11. BIRTHPLACE (State or foreign country) Webester County, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert Isaac Magoffin BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Olive I. Shiveley BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No 519-07-7560
17. INFORMANT'S OWN SIGNATURE Clarence W. Magoffin ADDRESS Shoshone, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Arteriosclerosis 420 — INTERVAL BETWEEN ONSET AND DEATH 10 Mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 14, 1967, to Aug 14, 1967, that I last saw the deceased alive on Aug 14, 1967 and that death occurred at 10:20A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 386
23b. ADDRESS Box 68 Shoshone Idaho
23c. DATE SIGNED 8-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-17-1967
24c. NAME OF CEMETERY OR CREMATORY Shoshone Cemetery
24d. LOCATION (City, town, or county) (State) Shoshone, Idaho

DATE REC'D BY LOCAL REG. 8-16-67
REGISTRAR'S SIGNATURE Francis M. Bergin
25. EMBALMER Francis M. Bergin
LICENSE NO. E-463
FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
AUG 30 1967
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 3656
Local Reg. No. 650
Reg. Dist. No. 430

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 320 Lincoln
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
c. LENGTH OF STAY (in this place) 100 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 320
b. COUNTY Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Alva	James	Lewin	Aug.	26,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 20, 1895	71	11	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Railroader 10	---	Sac City, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Lewin	Warren Co., Iowa	Mary Hochschwender	Fonda, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW I 3	712-07-7260	Taker D Lewin	Shoshone, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cirrhosis Sclerotic Liver Disease — INTERVAL BETWEEN ONSET AND DEATH 10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19 50, *to* August, 19 67, *that I last saw the deceased alive on* August 18, 19 67, *and that death occurred at* 2:04 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Taker D Lewin MD 386	1 Box 68 Shoshone Idaho	8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-26-67	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-29-1967	Francis M. Bergin	Francis M. Bergin	E-463

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bergin Funeral Chapel

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 22 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3657
Local Reg. No. 651
Reg. Dist. No. 430

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 8 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 320 Lincoln 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone Rural
c. LENGTH OF [illegible] (If outside place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Enroute to Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 320
b. COUNTY Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Henry
b. (Middle) Arthur
c. (Last) Burris

4. DATE OF DEATH (Month) Aug. (Day) 30, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: Apr. 1, 1917
9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR Months 4 Days 29 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Semi-Retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Norwood, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Warren Burris — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Sarah Coffman — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW 11 4
16. SOCIAL SECURITY NO. 486-24-3932
17. INFORMANT'S OWN SIGNATURE: X Norman Burris — ADDRESS: Hermiston, Ore.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Stem Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 30, 1967 *to* Aug 30, 1967, *that I last saw the deceased alive on* Aug 30, 1967, *and that death occurred at* 10:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title) Coroner 4
23b. ADDRESS: Box 68 Shoshone Idaho
23c. DATE SIGNED: 9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-2-1967
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 9-6-67
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3658
Local Reg. No. 652
Reg. Dist. No. 438

BIRTH NO.

SEP 11 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 320 Lincoln
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Woodriver Convalescent Center 320

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 016
b. COUNTY Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Emary b. (Middle) c. (Last) Sumner

4. DATE OF DEATH (Month) (Day) (Year) August 31, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Jaunary 5, 1895

9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Golax, Virgina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs Lee B Brush — ADDRESS Rockford

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 6 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1967, *to* 8-31, 1967, *that I last saw the deceased alive on* 8-31, 1967, *and that death occurred at* 10:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 386 / MD

23b. ADDRESS Box 68 Shoshone Idaho

23c. DATE SIGNED 9-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 5, 1967

24c. NAME OF CEMETERY OR CREMATORY Hailey Cemetery

24d. LOCATION (City, town, or county) Hailey (State) Idaho

DATE REC'D BY LOCAL REG. 9-9-67

REGISTRAR'S SIGNATURE Francis M. Bergin

25. EMBALMER Keith Bird [signature] — LICENSE NO. E 373

FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3659
Local Reg. No. 39
Reg. Dist. No. 630

RECEIVED AUG 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 331 Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Rexburg RFD 1
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 337 Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg RFD 1
d. STREET ADDRESS (If rural, give location) RFD 1

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Barber c. (Last) Clark

4. DATE OF DEATH (Month) July (Day) 29, (Year) 1967

5. SEX Male

6. COLOR OR RACE Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Oct. 30, 1892

9. AGE (In years last birthday) 74
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Menan, Idaho

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Peter Rose Clark
BIRTHPLACE Farmington, Utah

14. MOTHER'S MAIDEN NAME Martha Rozella Hall
BIRTHPLACE Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-34-9334

17. INFORMANT'S OWN SIGNATURE Lela C. McCulloch
ADDRESS Thornton

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 29, 1953, *to* June 20, 1967, *that I last saw the deceased alive on* June 20, 1967, *and that death occurred at* ? m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 537 A. Lundal, M. D.

23b. ADDRESS Rexburg, Idaho

23c. DATE SIGNED 8-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/1/67

24c. NAME OF CEMETERY OR CREMATORY Little Butte Cemetery

24d. LOCATION (City, town, or county) (State) Annis, Jefferso Co., Idaho

DATE REC'D BY LOCAL REG. 8-1-67

REGISTRAR'S SIGNATURE Leona Flamm

25. EMBALMER Russell Flamm

LICENSE NO. E-254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3660
Local Reg. No. 41
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 331 Madison 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 260 Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): Route # 2 Box 243

3. NAME OF DECEASED (Type or Print)
a. (First): Willard
b. (Middle): A. (Bill)
c. (Last): Moore

4. DATE OF DEATH (Month) (Day) (Year): August 26 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: January 14, 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Spanish Fork, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Thomas Moore — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Annie L. Anderson — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 519 26 3832A
17. INFORMANT'S OWN SIGNATURE: Edris Moore — ADDRESS: Rigby, Idaho

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension — yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes Mellitus.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* Aug, 1967, *that I last saw the deceased alive on* Aug 26, 1967, *and that death occurred at* 4 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Blair H Passey 409 (Degree or title)
23b. ADDRESS: Ashton Idaho
23c. DATE SIGNED: 8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/30/67
24c. NAME OF CEMETERY OR CREMATORY: Shelton Ririe Cemetery
24d. LOCATION (City, town, or county): Bonneville County (State): Idaho

DATE REC'D BY LOCAL REG.: 9-11-67
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Ralph M. Wood — LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3661
Local Reg. No. 66
Reg. Dist. No. 450

RECEIVED AUG 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 340 Minidoka 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
Statement OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hosp. 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert (rural)
d. STREET ADDRESS (If rural, give location) 476 So. 100 West

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Abigail	Done	McCombs	Aug. 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Oct. 28, 1898	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Smithfield, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Done	Utah	Abigail Raymond	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - -	518-42-0848	A. W. McCombs	Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebro-vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 10, 1967, *to* Aug. 6, 1967, *that I last saw the deceased alive on* Aug 5, 1967, *and that death occurred at* 1:30 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. W. Crawford, M.D.	740	Rupert, Idaho	8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/9/67	Riverside Cemetery	Heyburn, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-11-67	Mary Ellen Parker	Harold Payne	E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 23 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3662
Local Reg. No. 62
Reg. Dist. No. 453

67-8042 RECEIVED STATE OF IDAHO
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 340 Minidoka — SEP 13 1967 — 000
b. CITY OR TOWN Rupert — Bureau of Vital Statistics — c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South F Street Rupert 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340 — b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) South F Street Rupert Idaho

3. NAME OF DECEASED (Type or Print): a. (First) un named — b. (Middle) — c. (Last) Brethauer

4. DATE OF DEATH: (Month) (Day) (Year) Aug 23 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: Aug 23 1967

9. AGE (In years last birthday) — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Rupert Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Born out of wedlock no permission to use name — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Carrol Brethauer — BIRTHPLACE: Greely Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Carol Brethauer — ADDRESS: South F St Rupert

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Miscarriage at 5 months gegastation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) nervousness and no prenatal care
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident / — **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) 00 — **21c. (CITY, TOWN, OR TOWNSHIP)** 00 **(COUNTY)** 000 **(STATE)**

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m. — **21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — **21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* Did not see alive, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert C. Walk — 583 (Degree or title) Coroner 4 — **23b. ADDRESS**: 710 6th street Rupert Idaho — **23c. DATE SIGNED**: 8-28-1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Aug 28-67 — **24b. DATE**: Cremation — **24c. NAME OF CEMETERY OR CREMATORY**: Rupert Crematory — **24d. LOCATION** (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: 9-11-67 — **REGISTRAR'S SIGNATURE**: Mary Esther Barker — **25. EMBALMER**: Robert C. Walk — **LICENSE NO.**: E294

FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 8 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3663
Local Reg. No. 27
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 340 Minidoka — 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert — LENGTH OF STAY (in this place) 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — 070 — b. COUNTY Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
d. STREET ADDRESS (If rural, give location) 319 South Main Street

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 213 Linden Street 000

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	John	Emery	Simmers	August 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Oct. 13, 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Crane Operater-Aircraft
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Aurelia Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William A. Simmers, — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Mary Ellis Rice — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-09-0725
17. INFORMANT'S OWN SIGNATURE x Hazel Smith — ADDRESS 319 South Main Hailey

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-28, 1967, *to* 8-28, 1967, *that I last saw the deceased alive on* 8-28, 1967, *and that death occurred at* 5:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
740 W. W. Crawford, M.D.	Rupert, Idaho	8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 1, 1967	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-7-67	Mary Ellen Larson	Robert C. Walk	E 294

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: WALK MORTUARY

DUTIES:

SEP 11 1967

JAN 7 1983

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-8047 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3664
Local Reg. No. 191
Reg. Dist. No. 220

BIRTH NO.

AUG 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) Life 405
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1527 Cedar

3. NAME OF DECEASED (Type or Print)
a. (First) TRACY
b. (Middle) DENISE
c. (Last) PREUSSLER

4. DATE OF DEATH (Month) (Day) (Year) 1 August 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH 1 August 1967
9. AGE (In years last birthday) - - - - | IF UNDER 1 YEAR Months - - Days - - | IF UNDER 24 HRS. Hours 5 Min. 42

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Melvin Preussler
BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Theo Hamilton
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Melvin Preussler
ADDRESS Lewiston, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7735

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Respiratory Distress Syndrome
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth, *19___, to _____, 19___, that I last saw the deceased alive on* Aug 1, *19*67, *and that death occurred at* 10 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE 325 (Degree or title) J W Mannchuck MD 1
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED 8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 5 Aug 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 8-15-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER W. E. Black
LICENSE NO. E-426
Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED IDAHO

State File No. 3665
Local Reg. No. 184
Reg. Dist. No. 22a

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 35/ Nez Perce — AUG 18 1967 — Bureau of Vital Statistics
b. CITY OR TOWN: Lewiston
c. LENGTH OF STAY IN: 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Is Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): no record

3. NAME OF DECEASED (Type or Print): a. (First) Katherine b. (Middle) C. c. (Last) Lehman

4. DATE OF DEATH: (Month) August (Day) 2, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
female	white	divorced	July 7, 1902	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
records librarian 21	Hospital	Minnesota	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
no record	no record	no record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no record	Steve Vassar	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Coronary infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-2, 1967, *to* 8-2, 1967, *that I last saw the deceased alive on* 8-2, 1967, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	Lewiston, Idaho	8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal	August 4, 1967	Spokane, Washington	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-4-67	Lynette Knott	J. Vassar	E 297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

SEP 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 5 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3666
Local Reg. No. 188
Reg. Dist. No. 220

RECEIVED AUG 18 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 357 Nezperce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 302 Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Craigmont
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Frank b. (Middle) Ivan c. (Last) Kizzier

4. DATE OF DEATH (Month) (Day) (Year) August 2 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH Sept. 8, 1890

9. AGE (In years last birthday) 76 If under 1 year: Months Days If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber, retired 21

10b. KIND OF BUSINESS OR INDUSTRY Barber

11. BIRTHPLACE (State or foreign country) Mound City, Mo.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ivan Kizzier BIRTHPLACE Mound City, Mo.

14. MOTHER'S MAIDEN NAME Eliza Gobble BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WWI 3

16. SOCIAL SECURITY NO. 518 14 5559

17. INFORMANT'S OWN SIGNATURE Neal Lockridge ADDRESS Craigmont, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 4-5 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive Chronic.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* 8-2, 1967, *that I last saw the deceased alive on* 8-2, 1967, *and that death occurred at* 3:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE David D. McMahon 359 (Degree or title)

23b. ADDRESS Lewiston Idaho

23c. DATE SIGNED 8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial3

24b. DATE 8-5-67

24c. NAME OF CEMETERY OR CREMATORY I O O F Cemetery

24d. LOCATION (City, town, or county) (State) Craigmont, Idaho

DATE REC'D BY LOCAL REG. 8-10-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER Patrick Mahoney LICENSE NO. E492

FIRM NAME: Clovis Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 14 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3667
Local Reg. No. 185
Reg. Dist. No. 220

RECEIVED
AUG 1 8 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 350 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Rural
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3316-15th St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 350 b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston, (Rural)
d. STREET ADDRESS (If rural, give location) 3316-15th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Herman		Moye	Aug. 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	Widowed 2	Feb 4, 1878	89		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
retired carpenter	21	New York, N.Y.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
no record		no record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		444-07-1042	LaVerne Beashers	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia 493X — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Infirmities of Age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/12, 1967, *to* 8/3/67, 19___, *that I last saw the deceased alive on* 7/21/67, 19___, *and that death occurred at* 9:15 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Leon Glover MD	939 Bryden Ave., Lewiston, Ida.	8/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 1, 1967	Normal Hill Cemetery	Lewiston, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-4-67	Lynette Knott	Andrew F. Vassar	E 315

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 13 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3668
Local Reg. No. 189
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 20 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1014 Burrell Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) ORA
b. (Middle) D.
c. (Last) TOOPS

4. DATE OF DEATH (Month) (Day) (Year) August 5, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 11/5/1881
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) LaCygne, Kansas
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Nick Whisner — BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Elizabeth Dodd — BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 12 4977A
17. INFORMANT'S OWN SIGNATURE Helen Toops — ADDRESS Lewiston Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

144X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inanition

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Carcinoma of mouth
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH: 2-3 mos

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-26, 1947, *to* 8-5, 1967, *that I last saw the deceased alive on* 7-31, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE R W Eastwood 152 (Degree or title) MD
23b. ADDRESS Lewiston Idaho
23c. DATE SIGNED 8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial
24b. DATE 3 8 Aug. 1967
24c. NAME OF CEMETERY OR CREMATORY Vineland Cemetery
24d. LOCATION (City, town, or county) (State) Clarkston, Washington

DATE REC'D BY LOCAL REG. 8-10-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Patrick Mahoney — LICENSE NO. E-492

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: MERCHANT FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3669
Local Reg. No. 192
Reg. Dist. No. 220

BIRTH NO.

RECEIVED AUG 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 35 years
d. FULL NAME OF HOSPITAL OR INSTITUTION Usual Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 NezPerce
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) 1527 - Prospect Ave.

3. NAME OF DECEASED (Type or Print): a. (First) ARNOLD b. (Middle) WILLIAM c. (Last) DODEL

4. DATE OF DEATH: (Month) (Day) (Year) 7 August 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 16 Sept. 1888

9. AGE (In years last birthday): 78 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Clerk 10

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Milwaukee, Wisconsin

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank W. Dodel — BIRTHPLACE: Switzerland

14. MOTHER'S MAIDEN NAME: ? Blaze — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1905-1910

16. SOCIAL SECURITY NO.: 3

17. INFORMANT'S OWN SIGNATURE: William A. Dodel — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 mnths

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bronchial Asthma — YN

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1959, *to* Aug 7, 1967, *that I last saw the deceased alive on* Aug 7, 1967, *and that death occurred at* 6:30 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] (Degree or title) MD — 23b. ADDRESS: 301 St John Way — 23c. DATE SIGNED: 8/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 9 Aug 1967 — 24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery — 24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-15-67 — REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel — LICENSE NO. E-295

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3670
Local Reg. No. 196
Reg. Dist. No. 220

BIRTH NO. SEP 8 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 16
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3542 - 13th Street 'C'

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ELLEN	MATTSON	KING	9 August 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Married 3	16 Jan 1907	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Keewatin, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William R. Mattson	Finland	Catherine Harmela	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	529 42 0682	X Kathleen T. King	Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myasthenia Gravis	2 yrs.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 7 Aug. *, 1967, to* 9 Aug. *, 1967, that I last saw the deceased alive on* 9 Aug. *, 1967, and that death occurred at* 1:15 PM. *, from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B C Stern	496 M D	Lewiston Ida.	14 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	12 Aug 1967	Vineland Cemetery	Clarkston, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-22-67	Lynette Knott	L. E. DeBaun	E-295

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 8 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3671
Local Reg. No. 197
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 632 Burrell

3. NAME OF DECEASED (Type or Print)
a. (First): ESTHER
b. (Middle): LEONA
c. (Last): McINTYRE

4. DATE OF DEATH (Month) (Day) (Year): 13 August 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 18 Nov. 1902
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Genesee, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James F. Willows — BIRTHPLACE: Omaha, Nebr.
14. MOTHER'S MAIDEN NAME: Maude L. Ingle — BIRTHPLACE: Bloomfield, Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 36 1249
17. INFORMANT'S OWN SIGNATURE: John R. McIntyre — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma rectum 154X

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) wide spread metastasis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 27 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1965, *to* Aug. 13, 1967, *that I last saw the deceased alive on* Aug 13, 1967, *and that death occurred at* 11:30 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE 028 (Degree or title): John F. Barnes, M.D.
23b. ADDRESS: 347 St Palms Way Lewiston Idaho
23c. DATE SIGNED: 8.16.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 16 Aug 1967
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gardens.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 8-22-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

SEP 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3672
Local Reg. No. 195
Reg. Dist. No. 220

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce — SEP 8 1967 — 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Usual Residence 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1415 Ripon Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	ARTHUR	NMI	HORYNA		14	Aug	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	31 Oct 1908	58				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
04 Truck Gardener		Timkin, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Horyna	Europe	Rose Stesjkal	Europe

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	no record	Margaret E Hory	Lewiston, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock & Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gun Shot wound
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Suicide 2	Own Residence 01	Lewiston 13	NezPerce 351	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
14 Aug 1967 6:30AM	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Self inflicted gun shot.

22. *I hereby certify that I attended the deceased from* - - - - - *19* - - *to* - - - - - *19* - - *that I last saw the deceased alive on* - - - - - *19* - - *and that death occurred at* 6:30 AM *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wilfred Schuler	583 NezPerce Co. Coroner	Lewiston, Idaho	15 Aug 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	19 Aug 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-22-67	Lynette Knott	L. E. DeBaun	E-295
		FIRM NAME: Malcom's Brower-Wann Memorial Chapel	

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 8 1967

JUL 16 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

APR 10 1975

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3673
Local Reg. No. 198
Reg. Dist. No. 220

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 SEP 8 1967 108
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY IN THIS PLACE: 8 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Hoseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 628 Burrell

Bureau of Vital Statistics

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RALPH	A.	BOND	August 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	6/22/1901	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Trailer Park Owner 22	Self Employed	Miami, Missouri	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Amos Martin Bond	Iowa	Laura Catherine Young	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 03 5821	Mrs Loyd Bond	Lewiston, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma Large — INTERVAL BETWEEN ONSET AND DEATH: 14 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bowel
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—	—	—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* May 15, 1966, *to* 8-16, 1967, *that I last saw the deceased alive on* 8-16, 1967, *and that death occurred at* 7:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M Merchant 349	MD	Lewiston Idah	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal Burial	19 Aug 1967	Vineland Cemetery	Clarkston, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-24-67	Lynette Knotts	M Merchant	FDS

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: MERCHANT FUNERAL HOME

SEP 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

State File No. 3674
Local Reg. No. 194
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce — SEP 8 1967 — 103
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (In this place) 3 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Summerville Home 13L

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 258
b. COUNTY Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kooskia
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Anton	Emil	Matson	August 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 1 HR.: Hours / Min.
Male	white	Widowed 2	Nov. 20, 1883	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agr. - Own land	Forlanda, Sweden	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Johan Matson	Sweden	Anna Matilda Peterson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-03-7900	Harold Matson	Kooskia

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary occ	
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec, 1962 *to* Aug 17, 1967, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 7:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
John E. Cossman MD (Degree or title)	Lewiston Idaho	19 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR ~~CREMATORY~~	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 19, 1967	Pine Grove	Kooskia Idaho Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-21-67	Lynette Knotts	Patrick Mahoney	E-492

FIRM NAME: Trenary funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3675
Local Reg. No. 193
Reg. Dist. No. 220

RECEIVED
Bureau of Vital Statistics
SEP 8 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce — 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital — 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 35 Yakima
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parker
d. STREET ADDRESS (If rural, give location) (Parker is near Wapato, Wn.)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LORRAINE	no record	WALKER	19 August 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Indian	Married 3	30 Nov. 1923	43				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Ahtanum, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Wynaco	Washington	Lena Henry	Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No Reocrd	Edith Lampson	Wapato, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

7934

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Nephritis
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-18, 1967 *to* 8-19, 1967, *that I last saw the deceased alive on* 8-19, 1967, *and that death occurred at* 12:05 AM *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
D.O. (Degree or title)	1626 5th Ave Lewiston, Idaho	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	20 Aug 1967	Hopkins Mortuary	Toppenish, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-21-67	Lynette Knott	L. E. DeBaun	E-295

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 17 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 4 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3676
Local Reg. No. 201
Reg. Dist. No. 220

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 35 Nez Perce — SEP 8 1967 — 303

b. CITY OR TOWN: Lewiston — c. LENGTH OF STAY (in this place): wk.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY: NezPerce 35

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

d. STREET ADDRESS (If rural, give location): 1610 - 3rd Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CORA	G.	McCREEDY	19 August 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	26 March 1901	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Blackhammer, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gundar Dahler	Norway	Helga Johnson	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	540 20 3456D	Robert J. McCreedy	Anchorage, Alaska

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 992X VIRAL HEPATITIS — INTERVAL BETWEEN ONSET AND DEATH: 5 MOS

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 3/21, 1967, *to* 8/19, 1967, *that I last saw the deceased alive on* 8-19 1967, *and that death occurred at* 5 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	307 J St Lewiston	8/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	22 Aug 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-29-67	Lynette Knott Ma	L. E. DeBaun com's Brower-WAnn Memorial Chapel	E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

SEP 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 13 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3677
Local Reg. No. 200
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 8 1967

1. PLACE OF DEATH
a. COUNTY 351 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (If in this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bollinger Hotel

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 420-Warner

3. NAME OF DECEASED (Type or Print)
a. (First) Glenn
b. (Middle) Gentry
c. (Last) Farthing

4. DATE OF DEATH (Month) (Day) (Year) 8-22-67

5. SEX male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH 8-22-1909
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR: Months 0 Days 0 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) clerk 25
10b. KIND OF BUSINESS OR INDUSTRY Bollinger Hotel
11. BIRTHPLACE (State or foreign country) Cottonwood, Idaho.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Steve Farthing — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Mary V. Gentry — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) W.W.11 4
16. SOCIAL SECURITY NO. 518-10-7706
17. INFORMANT'S OWN SIGNATURE Glenna R. Farthing — ADDRESS 420 Warner Lewiston

9196

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) shock and Hemhorrage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — gunshot wound in chest — munites

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Acc 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) bathroom 01
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 351 **(STATE)** Lewiston NezPerce, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 22.67 7:30PM m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? bullet bounced off brick wall struck him

22. *I hereby certify that I attended the deceased from* 2 2, *19*__, *to* —, *19*__, *that I last saw the deceased alive on* —, *19*__, *and that death occurred at* 7:30PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Wilfred J. Duclos — 583 (Degree or title) coroner
23b. ADDRESS 4 Lewiston, Idaho
23c. DATE SIGNED 8/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 8-26-67
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memorial Gardens
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho.

DATE REC'D BY LOCAL REG. 8-25-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar
LICENSE NO. E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3678
Local Reg. No. 202
Reg. Dist. No. 220

BIRTH NO.

RECEIVED

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce SEP 8 1967 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Bureau of Vita
c. LENGTH OF STAY (in this place) Statistics ys
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 350 b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lenore
d. STREET ADDRESS (If rural, give location) Cherry Lanes Ranch

3. NAME OF DECEASED (Type or Print) a. (First) DIANA b. (Middle) LYNN c. (Last) KERBY

4. DATE OF DEATH (Month) (Day) (Year) 23 August 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH 3 May 1953

9. AGE (In years last birthday) 14 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student (8th grade)

10b. KIND OF BUSINESS OR INDUSTRY 03 Public School

11. BIRTHPLACE (State or foreign country) Lewiston, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Darrell C. Kerby — BIRTHPLACE Myrtle, Idaho

14. MOTHER'S MAIDEN NAME Janet Runyon — BIRTHPLACE Buhl, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE X Darrell C Kerby — ADDRESS Lenore, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5508 Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 Cahrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Vomiting during anesthesia — "
DUE TO (c) Appendicitis — 4 8hrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral anoxia.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____ 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 9:00 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE 325 (Degree or title) M.D.

23b. ADDRESS Lewiston, Idaho

23c. DATE SIGNED 8-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 26, 1967

24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memorial Gardens

24d. LOCATION (City, town, or county) Lewiston (State) Idaho

DATE REC'D BY LOCAL REG. 8-29-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER L. E. DeBaun — Maldom's Brower-Wann Memorial Chapel

LICENSE NO. E-295

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 8 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3679
Local Reg. No. 199
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 NezPerce 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 2days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555 Whitman
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pullman
d. STREET ADDRESS (If rural, give location) 105-North Spring

3. NAME OF DECEASED (Type or Print)
a. (First) George
b. (Middle) Eugene
c. (Last) Nottingham

4. DATE OF DEATH (Month) (Day) (Year) Aug. 24 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 26,1929
9. AGE (In years last birthday) 38 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) coeOwner Idaho Building Mainteance Co
10b. KIND OF BUSINESS OR INDUSTRY 22
11. BIRTHPLACE (State or foreign country) Fort Benton, Mont.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Oria M Nottingham — BIRTHPLACE Montana
14. MOTHER'S MAIDEN NAME Anna M. Johnson — BIRTHPLACE Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NO RECORD
17. INFORMANT'S OWN SIGNATURE Jacqualynne Nottingham — ADDRESS Pullman, Wn

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8184

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Basal Skull fracture — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 350 **(STATE)** NezPerce Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug 22 67 m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Car hit home

22. *I hereby certify that I attended the deceased from* 22 Aug 1967 *to* 24 Aug, 1967, *that I last saw the deceased alive on* 24 Aug, 1967, *and that death occurred at* 9:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE David W. Hemenford 227 (Degree or title) MD
23b. ADDRESS 307 St John's Way
23c. DATE SIGNED 25 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 8-25-1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Garden
24d. LOCATION (City, town, or county) GreatFalls, Mont (State)

DATE REC'D BY LOCAL REG. 8-25-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar
LICENSE NO. E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

SEP 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 18 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 2 1969

JAN 20 1970

JAN 18 1977

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Stack

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3680
Local Reg. No. 203
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 NezPerce SEP 8 1967 306
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 418- 6th St

3. NAME OF DECEASED (Type or Print)
a. (First) Albert
b. (Middle)
c. (Last) Mosman

4. DATE OF DEATH (Month) Aug (Day) 30, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan 16, 1888
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Uniontown, Wash.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Albert Mosman — BIRTHPLACE Holland
14. MOTHER'S MAIDEN NAME Crescentia Semlu — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-42-3070A
17. INFORMANT'S OWN SIGNATURE R. T. Mosman — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma bladder — INTERVAL BETWEEN ONSET AND DEATH 1½ yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1/13/67
19b. MAJOR FINDINGS OF OPERATION Carcinoma urinary bladder
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1961, *to* Aug 30, 1967, *that I last saw the deceased alive on* Aug 29, 1967, *and that death occurred at* 5:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Richard F. Stack, M.D. 492 (Degree or title)
23b. ADDRESS 307 St John Way Lewiston
23c. DATE SIGNED 9/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-2-67
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memorial Gardens
24d. LOCATION (City, town, or county) Lewiston, Idaho. (State)

DATE REC'D BY LOCAL REG. 8-31-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar — LICENSE NO. E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DCT 0 2 1991

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3681
Local Reg. No. 16
Reg. Dist. No. 530

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 360 Oneida
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad City
LENGTH OF STAY (in this place) half hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Oneida Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 360 b. COUNTY Oneida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad City
d. STREET ADDRESS (If rural, give location) 735 North 400 West

3. NAME OF DECEASED (Type or Print) a. (First) ARNOLD b. (Middle) - c. (Last) PEABODY

4. DATE OF DEATH (Month) July (Day) 22 (Year) 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH October 12, 1908

9. AGE (In years last birthday) 58 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04

10b. KIND OF BUSINESS OR INDUSTRY -

11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME ISAAC PEABODY BIRTHPLACE MALAD, IDAHO

14. MOTHER'S MAIDEN NAME ALICE K. EVANS BIRTHPLACE MALAD, IDAHO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) -

16. SOCIAL SECURITY NO. 518-18-6082

17. INFORMANT'S OWN SIGNATURE Ruth Peabody ADDRESS Malad, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction, Acute — Approx. 10 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 22, 1967 *to* July 22, 1967, *that I last saw the deceased alive on* July 22, 1967, *and that death occurred at* 3:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Joseph F. Wolf 314 (Degree or title) M.D.

23b. ADDRESS Malad, Idaho

23c. DATE SIGNED July 24, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE July 25, 1967

24c. NAME OF CEMETERY OR CREMATORY Malad City Cemetery

24d. LOCATION (City, town, or county) Malad Oneida (State) Idaho

DATE REC'D BY LOCAL REG. July 24, 67

REGISTRAR'S SIGNATURE Ruth G. Sweeten

25. EMBALMER Rayford G. Benson LICENSE NO. E-351

FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 25 1978

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3682
Local Reg. No. 10
Reg. Dist. No. 530

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 360 ONEIDA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) MALAD CITY
LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ONEIDA COUNTY HOSPITAL 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO b. COUNTY 360 ONEIDA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad City SPOUSE: David A. South
d. STREET ADDRESS (If rural, give location) 189 South Main St.

3. NAME OF DECEASED (Type or Print) a. (First) MRS. ELLA MINNIE b. (Middle) THOMAS c. (Last) SOUTH

4. DATE OF DEATH (Month) AUGUST (Day) 7 (Year) 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH June 23, 1889
9. AGE (In years last birthday) 78 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY -
11. BIRTHPLACE (State or foreign country) Tracy, Watauga, No. Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILLIAM THOMAS BIRTHPLACE Tracy, N. Carolina
14. MOTHER'S MAIDEN NAME BELL BRANOCK BIRTHPLACE Mtn. City, Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) - (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-62-7517
17. INFORMANT'S OWN SIGNATURE John G South ADDRESS Malad, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident, Acute — INTERVAL BETWEEN ONSET AND DEATH 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease, Chr. Compensated c Auricular Fibrillation — since Mid July '67

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7/22, 1967 to 8/7, 1967 that I last saw the deceased alive on Aug. 7, 1967, and that death occurred at 12:45 m., from the causes and on the date stated above.

23a. SIGNATURE Joseph F. Mele 314 (Degree or title) M.D.
23b. ADDRESS Malad, Idaho
23c. DATE SIGNED Aug. 8, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Aug. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY Malad City Cemetery
24d. LOCATION (City, town, or county) (State) Malad, Idaho

DATE REC'D BY LOCAL REG. Aug. 8, 1967
REGISTRAR'S SIGNATURE Ruth G. Sweeten
25. EMBALMER Raiford O. Benson, Malad
LICENSE NO. E-351

FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 24 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3683
Local Reg. No. 18
Reg. Dist. No. 530

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Oneida 360 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Malad Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 100
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coltman
d. STREET ADDRESS (If rural, give location): Idaho Falls Route # 2

3. NAME OF DECEASED (Type or Print)
a. (First): LILLIAN
b. (Middle): FRATES
c. (Last): BRIGHTON

4. DATE OF DEATH (Month) (Day) (Year): August 13, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: February 14, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Park City, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Frates — BIRTHPLACE: Portugal
14. MOTHER'S MAIDEN NAME: Huldean Johnson — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Not Avail.
17. INFORMANT'S OWN SIGNATURE: Max Brighton — ADDRESS: Milo, Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Septicemia 2nd decubitus ulcer sacrum
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* Aug 12, 1967 *that I last saw the deceased alive on* Aug 12, 1967, *and that death occurred at* 12 45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: J H Healey Jr — 315 (Degree or title)
23b. ADDRESS: Malad Idaho
23c. DATE SIGNED: Aug 22 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/16/67
24c. NAME OF CEMETERY OR CREMATORY: Elysian Gardens
24d. LOCATION (City, ~~town, or county~~) (State): Murray, Utah

DATE REC'D BY LOCAL REG.: 8-16-67
REGISTRAR'S SIGNATURE: Ruth G. Sweaten
25. EMBALMER: Raiford Guy Benson — Raiford G. Benson
LICENSE NO.: E351

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Benson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3684
Local Reg. No.
Reg. Dist. No.

RECEIVED
AUG 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Owyhee 370 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 370 b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Norma	J.	Pinkston	August 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	Mar. 27, 1927	40	4	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06		McCullins Mill, Keno, Oregon	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Julius Leonard Turnbull	unknown	Tressa Leona Olius	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	540-30-5778	X Arnold Penn	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7660 Incineration — INTERVAL BETWEEN ONSET AND DEATH: Instant.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) House Caught Fire & Burned

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 370 (STATE)
Accident 1	In Home 01	Homedale Owyhee Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21f. HOW DID INJURY OCCUR?
Aug. 5 1967 5:A m.		House burned

22. *I hereby certify that I attended the deceased from* Coroners investigation *only* Aug 5, 1967, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Andrew Warfield - Coroner 4	583	Homedale Idaho	Aug. 9 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 8, 1967	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug. 9'67	Andrew Warfield	Leonard C. Flahiff	E 481

FIRM NAME Homedale's Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3685
Local Reg. No. 46
Reg. Dist. No. 330

RECEIVED AUG 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN Payette
LENGTH OF STAY (in this place) 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 1603 1st Ave. So.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Walter	L.	Herrington	August 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	April 22, 1882	85	-	-	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Automobile Mechanic 21	Automotive	Forney, Texas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elias S. Herrington	Missouri	Jenny Mitchell	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- -	518-60-6294	Ruth M. Jensen	Payette, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

33X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident with right hemiplegia and speech aphasia — INTERVAL BETWEEN ONSET AND DEATH: 26 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ~~Diabetes~~ — years
DUE TO (c) Arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - - - - -	- - - - - - - - - -	- - - - - - - - - - - - - - - - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
- - - - - - - - - - - - - - - - - - -

OCT 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3686
Local Reg. No. 48
Reg. Dist. No. 330

Certificate of Death

RECEIVED
SEP 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Payette Valley Nursing Home 134

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 441
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): MYRTLE
b. (Middle): GARDNER
c. (Last): COBLE

4. DATE OF DEATH (Month) 8 (Day) 14 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: May 16, 1873
9. AGE (In years last birthday): 94 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Salina, Ohio
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Philip Gardner — BIRTHPLACE: Marysville, Ohio
14. MOTHER'S MAIDEN NAME: Mary E. Johnson — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Fern C Truell 106 N 8 A — ADDRESS: Grants Pass Ore

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease and failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1963, 19__, *to* Aug, 1967, *that I last saw the deceased alive on* 8-11-67, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Haddrard [illegible] 574
23b. ADDRESS: Payette Ida.
23c. DATE SIGNED: 8-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
24b. DATE: 8/17/67
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county): Weiser (State): Idaho

DATE REC'D BY LOCAL REG.: 8-21-1967
REGISTRAR'S SIGNATURE: Roberta E. Shaffer
25. EMBALMER: Marshall L. Dickerson Jr.
LICENSE NO.: E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3687
Local Reg. No. 47
Reg. Dist. No. 330

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 6 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route #1 South of City 006

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380 b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) Route #1, South of City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	B.	Ziegler	August 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Widowed 2	December 4, 1873	93	-- / --	- / -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Construction	Joplin, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Ziegler	Oklahoma	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	--	519-03-6541	Mrs. Edna Dunden	Payette Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic heart disease and failure — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Senility

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
- - - -	- - - - - - - - - - - - - - - - - - - -	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - - - - -	- - - - - - - - - - - -	- - - - - - - - - - - - - - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
- - - - - - - - m.		- - - - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* 1964, 19___, *to* 8-16-67 19___, *that I last saw the deceased alive on* 7-25-67, 19___, *and that death occurred at* 9:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 574	M.D.	Payette, Idaho	8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 19, 1967	Rosedale Mem. Park	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-19-1967	Roberta E. Shaffer	Gifford R. Shaffer	E-344

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 25 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3688
Local Reg. No. 29
Reg. Dist. No. 330

BIRTH NO.

SEP 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 380 Payette 316
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) About 16
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 9th St. N.& River Rd. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 00 Unknown
b. COUNTY 000 Unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Unknown
d. STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Gerald	Preston	Lloyd	Aug	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Unknown 0	8-2-29					

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Labor 04	Farming	Unknown	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.		150-22-1166	Hardy H Jackson	112½ N 8th Payette Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Fractured Skull — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident 1	Street 04	13 Payette	380 Payette	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒	NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Aug	19	67	2:30 pm			Auto Accident

22. *I hereby certify that I attended the deceased from* ~~[illegible]~~ Investigated *to* ~~[illegible]~~ *on* Aug 19, 19 67, *and that death occurred at* 2:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hardy H Jackson 583	Coroner 4	112½ N. 8th Payette, Ida	8/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	8/29/67	Rosedale Mem. Gardens	Payette	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-1967	Roberta E. Shaffer	Donald F. Brown	E-408

FIRM NAME: Chapel of the Roses. Payette

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3689
Local Reg. No. 7
Reg. Dist. No. 500-602

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Power 390 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home at Neeley 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 390
b. COUNTY: Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Neeley, 5 mi. SW Am. Falls
d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): ISABELLE
c. (Last): ZARING

4. DATE OF DEATH (Month) (Day) (Year): Aug. 3, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 16, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months 0, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Walla Walla, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hector McLean — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Margaret Loney — BIRTHPLACE: Ontario, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-42-8336-D
17. INFORMANT'S OWN SIGNATURE: Don Zaring — ADDRESS: American Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-22-, 1962, *to* 8-3-, 1967, *that I last saw the deceased alive on* 8-3-, 1967, *and that death occurred at* 2:A *m., from the causes and on the date stated above.*

23a. SIGNATURE Dillon MD 141 (Degree or title)
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-5-67
24c. NAME OF CEMETERY OR CREMATORY: Fallsview Cemetery
24d. LOCATION (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-10-67
REGISTRAR'S SIGNATURE: Colleen Godfried
25. EMBALMER: H. L. Davis — LICENSE NO. E-253

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3690
Local Reg. No. 8
Reg. Dist. No. 500-602

RECEIVED
AUG 24 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 390 Power 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural (Sanke River) | c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4 miles below Am. Falls dam 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 031 b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 3530 Valley Road

3. NAME OF DECEASED (Type or Print)
a. (First) DAVID b. (Middle) ALAN c. (Last) JONES

4. DATE OF DEATH (Month) (Day) (Year) August 12, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 1
8. DATE OF BIRTH Sept. 8, 1962
9. AGE (In years last birthday) 4 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 02
10b. KIND OF BUSINESS OR INDUSTRY xxxxx
11. BIRTHPLACE (State or foreign country) Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edison Dean Jones BIRTHPLACE Malad, Idaho
14. MOTHER'S MAIDEN NAME Margene Blankenship BIRTHPLACE Twin Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) xxxx
16. SOCIAL SECURITY NO. xxxx
17. INFORMANT'S OWN SIGNATURE Edison Dean Jones ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

850X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental drowning — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Snake River 18
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 390 (STATE) 4 miles below Am. Falls Dam Power Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 12, 1967 7:00p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Boat capsized

22. *I hereby certify that I attended the deceased from* ~~[illegible]~~ *last saw the deceased deaths on* Aug. 15, 1967, *and that death occurred at* 7:00p. *m., from the causes and on the date stated above.*

23a. SIGNATURE Bud Kelly 583 (Degree or title) Coroner 4
23b. ADDRESS American Falls, Idaho
23c. DATE SIGNED 8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 17, 1967
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. 8-22-67
REGISTRAR'S SIGNATURE Colleen Hodfield
25. EMBALMER [signature]
LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3691
Local Reg. No. 9
Reg. Dist. No. 500-602

RECEIVED AUG 29 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power 390 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place) 89 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) AUGUSTA
b. (Middle) HUSE
c. (Last) MAISCH

4. DATE OF DEATH (Month) (Day) (Year) Aug. 17, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 30, 1887
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR Months 11 Days 17 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Russiash, Poland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Karl H. Lehman — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Minnie Drews — BIRTHPLACE: Norwina, Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-10-8705
17. INFORMANT'S OWN SIGNATURE: x August Huse — ADDRESS: Am. Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C A of Large Bowel

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) [illegible]

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-17- 1967, *to* 8-17- 1967, *that I last saw the deceased alive on* 8-17- 1967 *and that death occurred at* 6:20P *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 141 (Degree or title)
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8-21-67
24c. NAME OF CEMETERY OR CREMATORY: Fallsview Cemetery
24d. LOCATION (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-25-67
REGISTRAR'S SIGNATURE: Colleen Hadfield
25. EMBALMER: H. L. Davis — LICENSE NO. E-253

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3692
Local Reg. No. 10
Reg. Dist. No. 510-602

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place) 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power 307
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CHRISTIAN	FREDERICK	ADOLF	August 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 14, 1892	74	11	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Blacksmith 21	Blacksmith Shop	Newberg, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ludwig Adolf	Russia	Lydia Weiler	Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	528-03-8404	Minnie Adolf	Am. Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A. Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 36 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-10- 19 67 *to* 8-18- 19 67, *that I last saw the deceased alive on* 8-18-67, 19___, *and that death occurred at* 7:20P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M.D.	American Falls, Idaho	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-22-67	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-67	Callen Hatfield	Bud Kelly Bud Kelly	E-467

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3693
Local Reg. No. 11
Reg. Dist. No. 500-602

RECEIVED
SEP 7 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Power 390 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bannock Creek
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 390
b. COUNTY: Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bannock Creek
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): MARTIN
c. (Last): PABAWENA

4. DATE OF DEATH (Month) (Day) (Year): August 27, 1967

5. SEX: Male
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 06
10b. KIND OF BUSINESS OR INDUSTRY: Ordnance plant
11. BIRTHPLACE (State or foreign country): Star Valley, Nevada
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Pabawena, Sr. — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Jane — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XX
16. SOCIAL SECURITY NO.: 518 26 4722
17. INFORMANT'S OWN SIGNATURE: Ben B. Pabawena — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

491X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Malnutrition; Senility
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I ~~attended the deceased from~~ ~~to~~ ~~that I last saw the deceased~~ ~~alive~~ on* Aug. 28, 1967, *and that death occurred at* 6:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE: Bud Kelly — 583 (Degree or title): Coroner 4
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 31, 1967
24c. NAME OF CEMETERY OR CREMATORY: Washakie Cemetery
24d. LOCATION (City, town, or county) (State): Washakie, Utah

DATE REC'D BY LOCAL REG.: 9-6-67
REGISTRAR'S SIGNATURE: Callen Gadfield
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3694
Local Reg. No. 12
Reg. Dist. No. 500-609

SEP 7 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Power County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Aberdeen
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
IRA	A. 000	VARGASON	Aug.	29,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Jan. 22, 1889	78	7	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	U of I Experiment Station	Marioville, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James I. Vargason	Iowa	Lydia Barnes	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		505-12-9578	Laura Vargason	Aberdeen, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-3-, 1963, *to* 8-29-, 1967, *that I last saw the deceased alive on* 7-7-67, 19___, *and that death occurred at* 10:40 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	American Falls, Idaho	8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	9-1-67	Aberdeen Cemetery	Aberdeen, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-6-67	[signature]	H. L. Davis	E-253

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc.

FEB 29 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3695
Local Reg. No. 50
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 402 Shoshone — AUG 14 1967 — 000
b. CITY OR TOWN Wallace — c. LENGTH OF STAY IN this place — Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Black Cloud — 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 402 — b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location) Black Cloud

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Dan	Willis	Cooper	August 1, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Never married	December 3, 1906	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	Poke County, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Cooper	Unknown	Elberta Hayden	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	518-05-2632	John Wilbur Cooper	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Aug. 1, 1967 Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 1, 1967, *to* Aug 1, 1967, *that I last saw the deceased alive on* Aug 1, 1967, *and that death occurred at* 3:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. M. Peterson, M.D. 414	Wallace Idaho	8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-8-67	Nine Mile Cemetery	Wallace, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-11-67	Dale L. Cornell	Dale L. Cornell	E 406

FIRM NAME Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 2 2 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3696
Local Reg. No. 49
Reg. Dist. No. 140

BIRTH NO.

AUG 21 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone 402 000
b. CITY OR TOWN Wallace (If outside corporate limits, write RURAL and give township) OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Providence 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 408 b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burke
d. STREET ADDRESS (If rural, give location) Box 45

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Irene	Mary	Rauch	August 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Oct. 16, 1916	50				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk 23	Retail	Spirit Lake, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Cummerford	N. Dakota	Nell Nagle	N. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	536-07-7528	X George E. Rauch	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5870

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug 28, 1967, *to* Aug 3, 1967, *that I last saw the deceased alive on* Aug 3, 1967, *and that death occurred at* 7:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred Mc Leod MD 168		Wallace Idaho	8-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-5-67	Shoshone Memorial	Pinehurst, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-8-67	Dale L Cornell	Dale L. Cornell	E 406

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

DEC 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3697
Local Reg. No. 65
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. STATE OF DEATH (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 400
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinecreek
d. STREET ADDRESS (If rural, give location): Star Route

3. NAME OF DECEASED (Type or Print)
a. (First): Lewis
b. (Middle): W.
c. (Last): Etherton

4. DATE OF DEATH (Month) (Day) (Year): Aug. 3, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 26, 1882
9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter
10b. KIND OF BUSINESS OR INDUSTRY: 21 Carpenter
11. BIRTHPLACE (State or foreign country): Carbondale, Ill.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Etherton
BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Julia Williams
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-01-3775
17. INFORMANT'S OWN SIGNATURE: William E. Etherton
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Cardiovascular Disease.
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): (Long history of)
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
1. Auricular fibrillation.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP): Kellogg (COUNTY): Shoshone (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/30/, 1967, *to* 8/3, 1967, *that I last saw the deceased alive on* 8/3/67, 19__, *and that death occurred at* 4:20 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Donald K. Pinkle 765 MD (Degree or title)
23b. ADDRESS: 204 Oregon St.
23c. DATE SIGNED: 8-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg Idaho

DATE REC'D BY LOCAL REG.: 8/8/67
REGISTRAR'S SIGNATURE: Joe Irvine
25. EMBALMER: Donald Maisel
LICENSE NO.: 452

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3698
Local Reg. No. 67
Reg. Dist. No. 142

RECEIVED
AUG 16 1967
505
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) En Route to Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 401 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 622 2nd Street

3. NAME OF DECEASED (Type or Print) a. (First) Howard b. (Middle) Cameron c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) Aug. 4, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Nov. 16, 1903

9. AGE (In years last birthday) 63
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Merchant

10b. KIND OF BUSINESS OR INDUSTRY Confectionary

11. BIRTHPLACE (State or foreign country) Malden, Mass.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Murdock Cameron
BIRTHPLACE Canada

14. MOTHER'S MAIDEN NAME Elizabeth Baker
BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-03-7236

17. INFORMANT'S SIGNATURE
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-4 1967, to 8-4, 1967, that I last saw the deceased alive on 8-4, 1967, and that death occurred at about 5:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE 414 (Degree or title) G. M. Peterson, M.D.
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 7, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg (State) Idaho

DATE REC'D BY LOCAL REG. 8-14-67
REGISTRAR'S SIGNATURE Joe Shine
25. EMBALMER Harold Hansen
LICENSE NO. 452
FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3699
Local Reg. No. 66
Reg. Dist. No. 142

RECEIVED
AUG 16 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 118A West Mill

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 407 b. COUNTY Shoshone
CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 118A West Mill

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Richard	B.	Crane	Aug 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	white	Married 3	May 20, 1906	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Warehouse Man of Mining		Wardner, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Crane	Mass.	Ann Lombard	Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-01-7965	Josephine Crane	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Massive Coronary Thrombosis	minutes
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Coronary artery disease	8 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized arteriosclerosis Gout	2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/11/59 *to* 8/7/67 *that I last saw the deceased alive on* 8/7/67 *and that death occurred at* 6:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen M. Whitsell 539	MD	Kellogg, Idaho	12 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	Aug. 10, 1967	Hazen & Jeager	Spokane, Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-14-67		Donald Maisel	E452

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 20 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3700
Local Reg. No. 52
Reg. Dist. No. 140

Certificate of Death

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gold Creek
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Logging Camp 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene, Idaho
d. STREET ADDRESS (If rural, give location): 115 1st Street

3. NAME OF DECEASED (Type or Print)
a. (First): Robert
b. (Middle): James
c. (Last): Rishor

4. DATE OF DEATH (Month) (Day) (Year): Aug. 11, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 5, 1939
9. AGE (In years last birthday): 28 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Logging
11. BIRTHPLACE (State or foreign country): Walkerville, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Earl Rishor — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Josephine Collins — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Viet Nam 8
16. SOCIAL SECURITY NO.: 519-38-7812
17. INFORMANT'S OWN SIGNATURE: x Mrs Carolyn Rishor — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9108

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Fracture cervical vertebrae with

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

~~DUE TO (b)~~ Compression &/or Transection of Spinal Cord. — INTERVAL BETWEEN ONSET AND DEATH: 10 min

DUE TO (c) Accident

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Skull fracture - Internal hemorrhage

19a. DATE OF OPERATION
19b. ~~MAJOR FINDINGS OF OPERATION~~: Fracture rt humerus & clavicle.
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Forest 09
21c. (CITY, TOWN, OR TOWNSHIP) 23 **(COUNTY)** 400 **(STATE)**: Gold Creek Shoshone Idaho.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8-11-67 6:30 a m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: hit by snag while hooking

22. *I hereby certify that I attended the deceased from* Never, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:30 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm J. Jancick 747 MD 1
23b. ADDRESS: Superior Mont
23c. DATE SIGNED: 8-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug 16-67
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: Aug 17-67
REGISTRAR'S SIGNATURE: Dale L Cornell
25. EMBALMER: Dale L. Cornell — LICENSE NO.: E 406

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

SEP 1 1967

DEC 28 1967

DEC 13 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3701
Local Reg. No. 68
Reg. Dist. No. 142

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED AUG 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 26 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 400
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Enaville
d. STREET ADDRESS (If rural, give location): Route 1, Box 34, Enaville, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Paul 141
c. (Last): Schuster

4. DATE OF DEATH (Month) (Day) (Year): Aug. 12, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 29, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Paul Schuster — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Johana Scharff — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-01-7352
17. INFORMANT'S OWN SIGNATURE: Mrs Wm Schuster — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

592X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Chronic Glomerulonephritis — 10 months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kellogg Shoshone Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 July, 1967, *to* 12 Aug, 1967, *that I last saw the deceased alive on* 12 Aug, 1967, *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Glen M. Whitwell 539 (Degree or title) M.D.
23b. ADDRESS: 204 Oregon, Kellogg
23c. DATE SIGNED: 15 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Post Falls
24d. LOCATION (City, town, or county) (State): Post Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-23-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Donald Maisel — LICENSE NO.: E452
FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 29 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 2 9 1994

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3702
Local Reg. No. 51
Reg. Dist. No. 140

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 402 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 402
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): 209 Pine Street

3. NAME OF DECEASED (Type or Print)
a. (First): Harley
b. (Middle): Lionel
c. (Last): Knowles

4. DATE OF DEATH (Month) (Day) (Year): August 13, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Mar. 3, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Chemist 21
10b. KIND OF BUSINESS OR INDUSTRY: AS &R
11. BIRTHPLACE (State or foreign country): Flat River, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John A. Knowles — BIRTHPLACE: Fredricktown, Mo.
14. MOTHER'S MAIDEN NAME: Laubelle Mitchell — BIRTHPLACE: Bongirre, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-01-9890
17. INFORMANT'S OWN SIGNATURE: X Mrs H. L. Knowles — ADDRESS:

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Occlusion
DUE TO (c): Athero Sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 13, 1967, *to* Aug 13, 1967, *that I last saw the deceased alive on* Aug 13, 1967, *and that death occurred at* 6 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Fitz Gerald 168 MD
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: Aug 14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Buriel
24b. DATE: 8-16-67
24c. NAME OF CEMETERY OR CREMATORY: St. Thomas
24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: 8-15-67
REGISTRAR'S SIGNATURE: Dale L Cornell
25. EMBALMER: Dale L. Cornell — LICENSE NO.: E 406

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 3703
Local Reg. No. 555
Reg. Dist. No. 140

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 400 Shoshone
SEP 8 1967
000
b. CITY OR TOWN: Rural Avery
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: 555 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): 3918 E. Hartson

3. NAME OF DECEASED (Type or Print): a. (First) Walter b. (Middle) H. c. (Last) Switzer

4. DATE OF DEATH: (Month) Aug. (Day) 17, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 12-17-08

9. AGE (In years last birthday): 60
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner-Manager 22

10b. KIND OF BUSINESS OR INDUSTRY: Switzer Communications

11. BIRTHPLACE (State or foreign country): Newberg, Oregon

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur Switzer
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Anna Allenbaugh
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: not available

17. INFORMANT'S OWN SIGNATURE: Mrs. Ernest Switzer
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8667 Fractured Skull, Severe

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Contusion of face & multiple lacerations, Crushed Chest

DUE TO (c) Compound Fracture of Right Knee & Proximal Tibia & Fibula, Crushing wound of Left Foot & Ankle, multiple Contusions abrasions & Lacerations Center body, Severe laceration of left upper lip

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Ruptured Spleen, Multiple laceration of lung & liver, Severe arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH: Few seconds

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hoodoo Ridge, Forest Of

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rural Avery 400 Shoshone Idaho

21d. TIME OF INJURY (Month) 8-17-67 (Day) (Year) (Hour) about 10:46 a.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Plane accident Hit top of tree after dropping logging supplies

22. *I hereby certify that I attended the deceased from* 8-17 1967 *to* 8-17, 1967, *that I last saw the deceased alive on* 8-17, 1967, *and that death occurred at* about 10:46 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: G. M. Peterson 414 (Degree or title): M.D.

23b. ADDRESS: Wallace Idaho

23c. DATE SIGNED: 8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-21-67

24c. NAME OF CEMETERY OR CREMATORY: Mt. View Cemetery

24d. LOCATION (City, town, or county) (State): Walla Walla, Wash.

DATE REC'D BY LOCAL REG.: Sept 6-67

REGISTRAR'S SIGNATURE: Wade Cornell

25. EMBALMER: Wade Cornell

LICENSE NO.: E 406

FIRM NAME: Colonial Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: SEP 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

*STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3704
Local Reg. No. 34
Reg. Dist. No. 140

RECEIVED SEP 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Avery
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California b. COUNTY 05 355 Alameda
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Berkeley
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Keith	A.	Switzer	August 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married 1	8-7-1939	28				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	University	Los Angeles, Calif.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter H. Switzer	Newberg, Oregon	BETHENE SHELTON	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Dates NA 0	N A	X Mrs. Ernest Switzer	Walla Walla

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 866X Fractured Skull, Crushed Chest,

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Fractured right [illegible], Fractured pack & mandible, Fractured Left Shoulder, Internal Injuries,

DUE TO (c) Multiple Contusions, abrasions, lacerations of entire body, but especially right arm, both hands, face & left knee

INTERVAL BETWEEN ONSET AND DEATH: Few seconds

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

20a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident	Hoodoo Ridge, Forest 09	Rural Avery	Shoshone	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
8-17-67 about 10:46 A.m.		Plane accident { hit top of tree after dropping logging supplies

22. *I hereby certify that I attended the deceased from* 8-17 *1967, to* 8-17, *1967, that I last saw the deceased alive on* 8-17, *1967, and that death occurred at* 10:46 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
T.M. Peterson	MD	Wallace, Idaho	8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8-21-67	Mt. View Cemetery	Walla Walla Wash

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 6-67	Dale L Carnell	Dale L Carnell	E 406

FIRM NAME: Carnell - Ward

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3705
Local Reg. No. 70
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 3-12
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 401
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 110 West Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): Dorothy
b. (Middle): I. 141
c. (Last): Fite

4. DATE OF DEATH (Month) (Day) (Year): Aug. 19, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 28, 1904
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Marcus Fite — ADDRESS: Kellogg Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Acute Cardiac Decomp — 2-3 weeks
DUE TO (c): Arteriosclerotic Heart Dis — 3-4 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Hypoalbuminemia, Fract. rt hip — unknown, 10 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kellogg Shoshone Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec., 1951, *to* 8/19, 1967, *that I last saw the deceased alive on* 8/19, 1967 *and that death occurred at* 3:50 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: Glen M. Whitlow 539 (Degree or title) MD
23b. ADDRESS: Kellogg Idaho
23c. DATE SIGNED: 22 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg Idaho

DATE REC'D BY LOCAL REG.: 8-25-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Donald Maisel — Maisel, Donald J.
LICENSE NO.: 452

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel Funeral Chapel

DUTIES:

FEB 1 8 1992

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to:

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-8116

BIRTH NO.

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 30 1967 Bureau of Vital Statistics

State File No. 3706
Local Reg. No. 71
Reg. Dist. No. 142

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 3-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 401
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): Apt. 206 Close In Apts.

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLES
b. (Middle): WILLIAM 141
c. (Last): MURRAY II

4. DATE OF DEATH (Month) (Day) (Year): Aug 21, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: Aug. 19, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 2; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Kellogg, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles W. Murray
BIRTHPLACE: Arizona
14. MOTHER'S MAIDEN NAME: Sharon L. Randall
BIRTHPLACE: No. Dak.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Charles William Murray
ADDRESS: 1st

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

522X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Acute Cardiac Failure — 36 hours
DUE TO (c): Juxta Position Major blood vessels. — Embryonic abnormality

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Dr Alton Stier, Pathology did the autopsy, Spokane, Wash
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kellogg Shoshone Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/19/, 1967, *to* 8/21, 1967, *that I last saw the deceased alive on* 8/21, 1967 *and that death occurred at* 12:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Glen M. Whitesel 539 (Degree or title) MD
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 22 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG: 8-25-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Donald Maisel
LICENSE NO.: 452

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3707
Local Reg. No. 69
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 3-02
b. CITY OR TOWN: Kellogg
LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 400 b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Page
d. STREET ADDRESS (If rural, give location): Page, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) C. 141 c. (Last) BRUMMETT

4. DATE OF DEATH: (Month) Aug. (Day) 21, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 1, 1945	21				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction Man II	Construction	Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James C. Brummett	Kansas	Sylvia Findley	Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	531-44-9261	x Mrs. Mary Brummett	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Severe Brain Injury — INTERVAL BETWEEN ONSET AND DEATH: 2d.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Lacerations. Scalp Abrasions Chest

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT ✓ SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
1	Highway 06	Enaville, Shoshone Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
8-19-67 1AM m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Car Wreck

22. *I hereby certify that I attended the deceased from* 8-19, 19 67, *to* 8-21, 19 67 *that I last saw the deceased alive on* 8-19-67 19, *and that death occurred at* 12:20 A m., *from the causes and on the date stated above.*

22a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	052 MD	Kellogg, Idaho	8.24.67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 24, 1967	Shoshone Mem. Gdns.	Pinehurst, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-67	[signature]	[signature]	E452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3708
Local Reg. No. 93
Reg. Dist. No. 142

BIRTH NO. 67-8119

RECEIVED SEP 8 1967 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
STATISTICAL OF STAY (in this place): few hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 400 COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinehurst
d. STREET ADDRESS (If rural, give location): Box 484 Pinehurst, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) MORRIS b. (Middle) JOHN 141 c. (Last) MERRICK

4. DATE OF DEATH (Month) (Day) (Year): August 25, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1

8. DATE OF BIRTH: Aug. 24, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days: 1 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Kellogg, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David Merrick
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Candice Wickstrom
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: David W. Merrick
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Above
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Inadequate Respiratory System.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kellogg Shoshone Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-24, 1967, *to* 8-25, 1967, *that I last saw the deceased alive on* 8-25, 1967, *and that death occurred at* 5:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 765 MD (Degree or title)
23b. ADDRESS: Kellogg Idaho
23c. DATE SIGNED: 8-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg Idaho

DATE REC'D BY LOCAL REG.: 9-1-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Robert G. Ross
LICENSE NO.: E-497
FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to:

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3709
Local Reg. No. 72
Reg. Dist. No. 142

RECEIVED SEP 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 40 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 27 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 400
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osburn
d. STREET ADDRESS (If rural, give location): Osburn, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) Florence b. (Middle) L. c. (Last) Chapman

4. DATE OF DEATH: (Month) Aug. (Day) 26, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow 2
8. DATE OF BIRTH: Dec. 26, 1887
9. AGE (In years last birthday): 79 — If UNDER 1 YEAR: Months / Days — If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Perry, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Thompson — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Anna Mae Blake — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Leland C. Franklin — ADDRESS: Osborn, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: two

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8-9-67
19b. MAJOR FINDINGS OF OPERATION: Metastatic Ca - Lung Bones
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-11-67, 19__, *to* 8-26-67 19__, *that I last saw the deceased alive on* 8-26-67 19__, *and that death occurred at* 7:10 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 052 (Degree or title) MD
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: Aug. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hayden Jaeger
24d. LOCATION (City, town, or county) (State): Spokane, Wash.

DATE REC'D BY LOCAL REG.: 9-1-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 16 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3710
Local Reg. No. 53
Reg. Dist. No. 140

BIRTH NO.

RECEIVED SEP 5 1967 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY: Shoshone 400
b. CITY OR TOWN: Pritchard 000
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 402
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): Dalton Trailor Court

3. NAME OF DECEASED (Type or Print): a. (First) Orbie; b. (Middle) Burdette; c. (Last) Dailey

4. DATE OF DEATH: (Month) August (Day) 29 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: May 11, 1934
9. AGE (In years last birthday): 33 — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Musician 23
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 526-96-3794
17. INFORMANT'S OWN SIGNATURE: X Personal records — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Skull, Crushed — INTERVAL BETWEEN ONSET AND DEATH: Two seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chest, Internal Injuries
DUE TO (c) Fractured Right Tibia & Fibula
Fractured Left Wrist
Severe Lacerations of scalp
Contusion of Face
Laceration Under Left Arm
Multiple Contusions & Abrasions

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 66
21c. (CITY, TOWN, OR TOWNSHIP) Pritchard (COUNTY) Shoshone 400 (STATE) Idaho
21d. TIME OF INJURY: (Month) 8 (Day) 29 (Year) 67 (Hour) about 12:05 p.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? One car accident - Ran off Highway

22. *I hereby certify that I attended the deceased from* 8-29 *1967, to* 8-29, *1967, that I last saw the deceased alive on* 8-29, *1967, and that death occurred at* 12:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: G.M. Peterson, M.D. (Degree or title) 414
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 8-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-1-67
24c. NAME OF CEMETERY OR CREMATORY: Willwood Burial Park
24d. LOCATION (City, town, or county) (State): Rockford, Ill.

DATE REC'D BY LOCAL REG.: 9-2-67
REGISTRAR'S SIGNATURE: Dale Cornell
25. EMBALMER: Dale L. Cornell
LICENSE NO.: E 406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 11 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3711
Local Reg. No. 75
Reg. Dist. No. 142

RECEIVED
SEP 15 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Prichard
c. LENGTH OF STAY (in this place): few min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rural Prichard, Idaho 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 401
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 423 Main St.

3. NAME OF DECEASED (Type or Print)
a. (First): EARNEST
b. (Middle): DARRELL
c. (Last): ROLLINS

4. DATE OF DEATH (Month) (Day) (Year): Aug. 29, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: June 4, 1945
9. AGE (In years last birthday): 22 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Service Station Man 06
10b. KIND OF BUSINESS OR INDUSTRY: Gas and Oil
11. BIRTHPLACE (State or foreign country): Oklahoma
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ernest G. Rollins — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Dorothy Haynes — BIRTHPLACE: Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-50-4405
17. INFORMANT'S OWN SIGNATURE: Earnest G. Rollins — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Compound, Comminuted fracture of skull — INTERVAL BETWEEN ONSET AND DEATH: Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Crushed Left Face + Chest
DUE TO (c) Compound, Comminuted fracture of left elbow, Internal Injuries

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Multiple Contusions & Abrasions

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 400 **(STATE)**: Rural Prichard, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8-29-67 about 12:05 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: automobile ran off road

22. *I hereby certify that I attended the deceased from* 8-29, 1967, *to* 8-29, 1967, *that I last saw the deceased alive on* 8-29, 1967, *and that death occurred at* about 12:05 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. M. Peterson, M.D. 414 1
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Sept. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 9-8-67
REGISTRAR'S SIGNATURE: Joe Shine
25. FUNERAL DIRECTOR: Donald Maisel — ADDRESS: Kellogg Ida.

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3712
Local Reg. No. 74
Reg. Dist. No. 143

RECEIVED SEP 15 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 400 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Prichard
STATISTICAL USE OF — LENGTH OF STAY (in this place): few min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Enroute To Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wardner
d. STREET ADDRESS (If rural, give location): 404 Main St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CAROLYN	SUE	ROLLINS	Aug. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Divorced 4	Dec. 17, 1937	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ralph Robertson	Illinois	Lilie Smith	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-40-6313	Personal Records	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Severe Internal Injuries — INTERVAL BETWEEN ONSET AND DEATH: about 1 hour

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)
accident	Highway 06	Rural Prichard, 13 Shoshone, 400 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
8-29-67 1:05 p.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	2 automobile ran off road

22. *I hereby certify that I attended the deceased from* 8-29 1967 *to* 8-29, 1967, *that I last saw the deceased alive on* 8-29, 1967, *and that death occurred at* 1:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
G. M. Peterson M.D. 414 (Degree or title)	Wallace, Idaho	9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 1, 1967	Arvin Dist. Cemetery	Arvin, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
9-8-67	Joe Shane	Ronald Hazel Kellogg Ida.	

Federal Security Agency
United States Public Health Service

Form DPH-48021

SEP 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Important, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3713
Local Reg. No.
Reg. Dist. No. 620

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Teton 410 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 418
b. COUNTY: Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
d. STREET ADDRESS (If rural, give location): R. F. D.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	EDNA	WINGER	PEACOCK	August 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	13 June 1967	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	----	Darby, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur Winger	Hyrum, Cache Co., Ut	Comilla Hill	Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	------		x Joseph W. Peacock	Driggs, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1230 Ventricular Asystole — Interval between onset and death: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Insufficiency — 7 days
DUE TO (c) Advanced Arteriosclerosis of the Coronary — 18 mo

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
			m.		

22. *I hereby certify that I attended the deceased from* July, 1961, *to* August 16, 1967, *that I last saw the deceased alive on* August 16, 1967, *and that death occurred at* 8:00A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
V. Head MD 219		Driggs, Idaho	8-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	19 Aug. 1967	Cache-Clawson Cemetery	Tetonia, Teton Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-67	Ella Griggs	Robert Bean	E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 27 1971

1. THE INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 30 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3714
Local Reg. No. 2
Reg. Dist. No. 620

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Teton 410 — SEP 8 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): His Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 410 b. COUNTY: Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print): a. (First) THEONE b. (Middle) MURLAND c. (Last) BROWN

4. DATE OF DEATH (Month) (Day) (Year): August 26, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 19 Feb. 1940
9. AGE (In years last birthday): 27 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm - Forest
11. BIRTHPLACE (State or foreign country): Rexburg, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Theodore Brown — BIRTHPLACE: Providence, Ut.
14. MOTHER'S MAIDEN NAME: Florence Knight — BIRTHPLACE: Clawson, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Jan. 61 -Dec. 65
16. SOCIAL SECURITY NO.: 518-42-8033
17. INFORMANT'S OWN SIGNATURE: Family and Court Records — ADDRESS: Driggs, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Multiple brain and head injuries, — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): and massive hemorrage due to self-
DUE TO (c): inflicted gun shot — Immediate

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP) Driggs 13 (COUNTY) Teton 410 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 26, 67 10 P.M. 2
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 5
21f. HOW DID INJURY OCCUR? Gun Shot

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 10:35 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE: A. J. Greene — 583 (Degree or title): Coroner 4
23b. ADDRESS: Driggs, Idaho
23c. DATE SIGNED: 9-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 30 Aug. 1967
24c. NAME OF CEMETERY OR CREMATORY: Pratt Ward Cemetery
24d. LOCATION (City, town, or county) (State): Alta, Teton Co., Wyoming

DATE REC'D BY LOCAL REG.: 9-5-67
REGISTRAR'S SIGNATURE: Ella Griggs
25. EMBALMER: Robert O. Bean
LICENSE NO.: E-456
FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3715
Local Reg. No. 3
Reg. Dist. No. 620

RECEIVED SEP 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Teton
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Victor
c. LENGTH OF STAY (in this place): 0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): On highway near Victor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Swanvalley
d. STREET / ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print): a. (First) b. (Middle) RULON TAYLOR c. (Last) ADAMS

4. DATE OF DEATH (Month) (Day) (Year): August 28, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 31, 1925

9. AGE (In years last birthday): 42
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter 21

10b. KIND OF BUSINESS OR INDUSTRY: Decoration

11. BIRTHPLACE (State or foreign country): St. George, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elmo Adams. BIRTHPLACE: St. George, Utah

14. MOTHER'S MAIDEN NAME: Fredonia M. Forsyth. BIRTHPLACE: Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 518-20-1904

17. INFORMANT'S OWN SIGNATURE: Goldie Adams ADDRESS: Ida. Swan Valley,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aneurysm of cerebral vessels — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES XX NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1961, *to* August 28, 1967, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 7:20A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title)

23b. ADDRESS: [illegible]

23c. DATE SIGNED: 9-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 31 AUG 67

24c. NAME OF CEMETERY OR CREMATORY: Rigby Pioneer

24d. LOCATION (City, town, or county) (State): Rigby, Jefferson, Idaho

DATE REC'D BY LOCAL REG.: 9-7-67

REGISTRAR'S SIGNATURE: Ella Griggs

25. EMBALMER: Bruce A. Eckersell LICENSE NO.: E236

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3716
Local Reg. No. D-267
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LIMITS OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 227 7th. Ave. North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 227 7th. Ave. North

3. NAME OF DECEASED (Type or Print)
a. (First): LAFAYETTE
b. (Middle): LEE
c. (Last): IRVIN

4. DATE OF DEATH (Month) (Day) (Year): Aug. 1, 1967 Approx.

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: Nov. 21, 1890
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dentist 15
10b. KIND OF BUSINESS OR INDUSTRY: Gen'l Practice
11. BIRTHPLACE (State or foreign country): Indianapolis, Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: L. L. Irvin — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Elizabeth --- — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. I 3 5
16. SOCIAL SECURITY NO.: 19 44 7666
17. INFORMANT'S OWN SIGNATURE: X Mrs Betty Jane Blowers — ADDRESS: Newport Beach, California

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Heart Artereoscleratic Disease
DUE TO (c): Old Age

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Investigation Only *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: H. Thad Scholes 583 (Degree or title) T.F. County Coroner 4
23b. ADDRESS: 120 Adams, Twin Falls 8-8-67
23c. DATE SIGNED: 8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 7
24b. DATE: Aug. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: 8-8-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 11 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3717
Local Reg. No. D-268
Reg. Dist. No. 460

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 3-08
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Twin Falls
c. LENGTH OF STAY IN THIS PLACE (In hospital or institution, give length of stay before death): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 016
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
d. STREET ADDRESS (If rural, give location): 218 East Walnut

3. NAME OF DECEASED (Type or Print)
a. (First): RHEA
b. (Middle): GENEVA
c. (Last): MILLER

4. DATE OF DEATH (Month) (Day) (Year): Aug. 1, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Nov. 27, 1889

9. AGE (In years last birthday): 77 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Abilene, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Beisicker — BIRTHPLACE: Penn.

14. MOTHER'S MAIDEN NAME: Harriet C. Owens — BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Fred Miller — ADDRESS: Hailey, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Myocardial Infarct — 8 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24, 1967, *to* 8-1, 1967, *that I last saw the deceased alive on* 8-1, 1967, *and that death occurred at* 8:45 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE, (Degree or title): D.A. McCluskey MD 338

23b. ADDRESS: Twin Falls Idaho

23c. DATE SIGNED: 8/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/4/67

24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery

24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: 8-8-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Keith Bird Keith Bird

LICENSE NO.: E-373

FIRM NAME: Bird Funeral Home, Hailey, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 25 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 24 1971
APR 6 1976

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 10 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3718
Local Reg. No. D-296
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 1-53
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 53 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 269 Heyburn

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLES
b. (Middle): V. JONES 143
c. (Last): JONES

4. DATE OF DEATH (Month) (Day) (Year): August 2, 1967

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: December 7,1890
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafe operator 23
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Linell Jones — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Carrie Shaw — BIRTHPLACE: Indiana
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-24-4678
17. INFORMANT'S OWN SIGNATURE: X Mrs. C. V. Jones — ADDRESS: Twin Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Coronary & chronic — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Congestive heart failure
cardiomegaly
DUE TO (c) Gen arteriosclerosis
old age

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 31, 1967, *to* Aug 2, 1967, *that I last saw the deceased alive on* Aug 2, 1967, *and that death occurred at* 9 25 *m., from the causes and on the date stated above.*

23a. SIGNATURE: M. C. Reiske MD 132 (Degree or title)
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: Aug.3,1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: August 7,1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls Idaho

DATE REC'D BY LOCAL REG.: 8-8-67
REGISTRAR'S SIGNATURE: [signature] Pamela J. Johnson
25. EMBALMER: [signature]
LICENSE NO.: E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

67-7142

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3719
Local Reg. No. D-375
Reg. Dist. No. 460

BIRTH NO.

AUG 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 3-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 141 Blue Lakes Blvd. South

3. NAME OF DECEASED (Type or Print)
a. (First): PAUL
b. (Middle): EDWARD 143
c. (Last): CARDWELL

4. DATE OF DEATH (Month) (Day) (Year): August 2, 1967

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married 1
8. DATE OF BIRTH: July 31, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 2; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --- 02
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Claude C. Cardwell
BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Pansy I. Chandler
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT'S OWN SIGNATURE: X Claude Cardwell
ADDRESS: Twin Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7625

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Neonatal atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 2d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Premature infant 1 lb - 5 oz. — 2d

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/31, 1967, *to* 8/2, 1967, *that I last saw the deceased alive on* 8/2, 1967, *and that death occurred at* 4:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. M. Myght 576 (Degree or title): MD
23b. ADDRESS: 676 Shoshone W. Twin Falls Idaho
23c. DATE SIGNED: Aug 3, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county): Twin Falls (State): Idaho

DATE REC'D BY LOCAL REG.: 8-8-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: [signature]
LICENSE NO.: E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3720
Local Reg. No. 0-274
Reg. Dist. No. 460

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 617 15th St. North

3. NAME OF DECEASED (Type or Print)
a. (First): Donald
b. (Middle): Jay 143
c. (Last): McCandless

4. DATE OF DEATH (Month) (Day) (Year): August 2, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 11, 1922
9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafe Owner 23
10b. KIND OF BUSINESS OR INDUSTRY: Lounge & Cafe
11. BIRTHPLACE (State or foreign country): Midvale, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: unknown — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW2 4
16. SOCIAL SECURITY NO.: 528-16-7619
17. INFORMANT'S OWN SIGNATURE: Mrs Don McCandless — ADDRESS: Buhl, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gun Shot Wound to Abdomen (Shot gun)

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death*: Uncontrollable hemorrhage from comm

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Perforated blown out intestine, large & small
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 00
21c. (CITY, TOWN, OR TOWNSHIP) 00 **(COUNTY)** 000 **(STATE)**
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 am, 1967, *to* 1:40 pm, 1967 *that I last saw the deceased alive on* 1:40 p, 1967 *and that death occurred at* 1:40p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Willard Utter 417
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: Aug. 7, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: August 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-8-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: [signature]
LICENSE NO.: E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary 733-6600

DUTIES:

AUG 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 25 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3721
Local Reg. No. D-578
Reg. Dist. No. 460

RECEIVED AUG 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 35 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): Clinton Dr.

3. NAME OF DECEASED (Type or Print): a. (First) HILDA; b. (Middle) 143; c. (Last) EVANS

4. DATE OF DEATH: (Month) (Day) (Year): Aug. 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months	Days	If UNDER 24 HRS.: Hours	Min.
female	white	widowed 2	June 28, 1878	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Sweden	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Johannas Bjorkman	Sweden	Carolina Berg	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- - - - -	529-18-6909	Mrs J. Alvin Brown	Twin Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic obliterans, rt. leg
DUE TO (c) Diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Infection of surgical amputation rt. leg

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - -	- - - - -	- - - - - - - - - - - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
- - - - - - - m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	- - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* 6-29, 1967, *to* 8-3, 1967, *that I last saw the deceased alive on* 8-3, 1967, *and that death occurred at* 9:55P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. W. Kendall 227 M.D.	Twin Falls, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal 3	8-5-67	Ogden City Cemetery	Ogden, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-11-67	Pamela J. Johnson	Dale R. Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 31 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3722
Local Reg. No. D-288
Reg. Dist. No. 460

Certificate of Death

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 3-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 609 11th Ave. N.

3. NAME OF DECEASED (Type or Print)
a. (First): ESTELLA
b. (Middle): MARIE 143
c. (Last): WHALEY

4. DATE OF DEATH (Month) (Day) (Year): Aug. 5, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 6, 1876
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Thurman, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leonard Ewell — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Hester F. Fletcher — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-54-4527
17. INFORMANT'S OWN SIGNATURE: Mrs Melvin Ewell 948 Robertson — ADDRESS: Buhl, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

241X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic Asthma (acute flare up) & Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 1 wk many years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9, 1965 *to* 8-5, 1967 *that I last saw the deceased alive on* 8-5-67, 19__, *and that death occurred at* 12:55 a. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Vern H Anderson, MD 011
23b. ADDRESS: Buhl, Idaho
23c. DATE SIGNED: 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/9/67
24c. NAME OF CEMETERY OR CREMATORY: Buhl
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 8.18.67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: Robert R. Dickard
LICENSE NO.: E-312

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3723
Local Reg. No. D-269
Reg. Dist. No. 460

Certificate of Death

RECEIVED
AUG 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): Skyview Manor

3. NAME OF DECEASED (Type or Print)
a. (First): Dr. JOHN
b. (Middle): P.
c. (Last): RITCHEY

4. DATE OF DEATH (Month) (Day) (Year): AUGUST 6th, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: January 13, 1878
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MD Medical Doctor 14
10b. KIND OF BUSINESS OR INDUSTRY: General
11. BIRTHPLACE (State or foreign country): Evansville, Ind.
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: James Ritchey — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 516060-8366
17. INFORMANT'S OWN SIGNATURE: Pauline Warner — ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Infarction of the myocardium due to — INTERVAL BETWEEN ONSET AND DEATH: 4201

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): coronary arteriosclerotic thrombosis — 15 min
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Chronic brain syndrome due to cerebral arteriosclerosis — 2 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 14, 1967, *to* Aug 4, 1967, *that I last saw the deceased alive on* Aug 4, 1967, *and that death occurred at* 11:15 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B. L. Kuilhamp M.D. 296
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 8.7.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 8.8.67
24c. NAME OF CEMETERY OR CREMATORY: Mt. View Memorial
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 8-8-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: [signature]
LICENSE NO.: 343

Federal Security Agency
United States Public Health Service
Form DH-65021
FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3724
Local Reg. No. D-229
Reg. Dist. No. 460

RECEIVED
AUG 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Nursing Home 250

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 1795 - 4th Ave. E.

3. NAME OF DECEASED (Type or Print): a. (First) LOTTIE b. (Middle) BELLE c. (Last) TAYLOR

4. DATE OF DEATH (Month) (Day) (Year): August 7, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: Sept. 25, 1881

9. AGE (In years last birthday): 85
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Nathan W. Webb
BIRTHPLACE: Wisconsin

14. MOTHER'S MAIDEN NAME: Anna Doubleday
BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-44-2432

17. INFORMANT'S OWN SIGNATURE: Geo. M. Taylor
ADDRESS: Kimberly, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ARTERIOSCLEROTIC HEART DISEASE — INTERVAL BETWEEN ONSET AND DEATH: 15 YRS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ARTERIOSCLEROSIS GENERALIZED — 15 YRS

DUE TO (c) RHEUMATOID ARTHRITIS — 15 Yr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): ---

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): ---

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): ---

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): --- m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: ---

22. *I hereby certify that I attended the deceased from* July 1961 *to* Aug 1967, *that I last saw the deceased alive on* Aug 6th, 1967, *and that death occurred at* 8:15 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: O. Ellis Knight 286 (Degree or title): M.D.

23b. ADDRESS: Kimberly, Idaho

23c. DATE SIGNED: Aug 9, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Aug 10, 1967

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls Idaho

DATE REC'D BY LOCAL REG.: 8-11-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: [signature]

LICENSE NO.: E-343

FIRM NAME: WHITE MORTUARY Twin Falls, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 20 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 21 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3725
Local Reg. No. 0-281
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH NO.

AUG 1 8 1967
Bureau of Vital Statistics

1. PLACE OF DEATH — a. COUNTY: Twin Falls 420 1-47	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho 420 b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl — c. LENGTH OF STAY (in this place): 47 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): R.F.D. # 1 000	d. STREET ADDRESS (If rural, give location): R.F.D. # 1

3. NAME OF DECEASED (Type or Print): a. (First) PEARL b. (Middle) CHERRY c. (Last) WILSON

4. DATE OF DEATH (Month) (Day) (Year): Aug. 7, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug. 16, 1888

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Chillicothe, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry A. Cherry — BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Ellen Sinnard — BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-40-9766

17. INFORMANT'S OWN SIGNATURE: Ruby Baugh — ADDRESS: RFD # 1, Buhl, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5271

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Cardiomegaly & Myocardial Insufficiency — 3 yrs

DUE TO (c) Pulmonary Emphysema and — 4-5 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Bronchial Asthma

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-21, 1953, *to* 8-7, 1961, *that I last saw the deceased alive on* 8-5, 1967, *and that death occurred at* 1:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: D. G. McCrosky MD 339 (Degree or title)

23b. ADDRESS: Twin Falls Idaho

23c. DATE SIGNED: 8-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/9/67

24c. NAME OF CEMETERY OR CREMATORY: Buhl

24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 8-14-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Robert F. Dickard

LICENSE NO.: E-312

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 12 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3726
Local Reg. No. D-280
Reg. Dist. No. 460

RECEIVED
AUG 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 431 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Twin Falls
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 431
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 345 8th Ave. North

3. NAME OF DECEASED (Type or Print)
a. (First): EDITH
b. (Middle): C.
c. (Last): BALIS 144

4. DATE OF DEATH (Month) (Day) (Year): August 8, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov. 24, 1896
9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Ianthe, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lewis K. Cole
BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Etta V. Crom
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-44-2036B
17. INFORMANT'S OWN SIGNATURE: Frank H Balis
ADDRESS: Twin Falls, I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Infarct — 2½ months
DUE TO (c) Residual Rt Hemaplegia Since 1948

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-20 19 47 *to* 8-8 19 67, *that I last saw the deceased alive on* 8-8 19 67, *and that death occurred at* 5:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): D. A. McQuisky MD 338
23b. ADDRESS: Twin Falls Idaho
23c. DATE SIGNED: 8/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 12, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-11-67
REGISTRAR'S SIGNATURE: Pamela J Johnson
25. EMBALMER:
LICENSE NO.: E-343

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining MAR 18 1976 signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3727
Local Reg. No. D-304
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 31 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 421
a. COUNTY: Twin Falls 3-15
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): R.F.D. # 3

3. NAME OF DECEASED (Type or Print)
a. (First): PEARL
b. (Middle): A. 143
c. (Last): GARRISON

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 13, 1891
9. AGE (In years last birthday): 76 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Baxter, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George W. Scott — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Lavina Rhodes — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-40-6450B
17. INFORMANT'S OWN SIGNATURE R+3: W. L. Garrison — ADDRESS: Buhl, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cirrhosis of Liber, Biliary type — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Ascites, marked — 2 weeks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-12, 1967, *to* 8-9, 1967, *that I last saw the deceased alive on* 8-9, 1967, *and that death occurred at* 9:12 p. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Vern H Anderson, MD 011
23b. ADDRESS: Buhl, Ida
23c. DATE SIGNED: 8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/11/67
24c. NAME OF CEMETERY OR CREMATORY: Buhl
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 8-28-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: Robert F. Dickard
LICENSE NO.: E-312

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3728
Local Reg. No. D-379
Reg. Dist. No. 460

RECEIVED
AUG 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Kansas 17
b. COUNTY: 555 Greenwood Coun
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eureka
d. STREET ADDRESS (If rural, give location): Box 442

3. NAME OF DECEASED (Type or Print)
a. (First): Eddie
b. (Middle): L 143
c. (Last): TODD

4. DATE OF DEATH (Month) (Day) (Year): Aug. 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 25, 1897

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Barber 21

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Iola, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Todd
BIRTHPLACE: Scotland

14. MOTHER'S MAIDEN NAME: Sarah Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): WWI Army 3

16. SOCIAL SECURITY NO.: 512-44-4739-A

17. INFORMANT'S OWN SIGNATURE: Lyle C Mendenhall, M.D.
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Infarction of myocardium	2 hours
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Coronary artery Thrombosis	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes mellitus Senile	34 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8-8, 1967, *to* 8-9, 1967, *that I last saw the deceased alive on* 8-9, 1967, *and that death occurred at* 1:40 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: George P. Brown MD (Degree or title)
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 8.9.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial-Removal
24b. DATE: Aug. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Eureka, Kansas

DATE REC'D BY LOCAL REG.: 8-10-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER:
LICENSE NO.: E-343
FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 16 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 23 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 18 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3729
Local Reg. No. 0-283
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 3-08
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 320
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dietrich Rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) DOROTHY b. (Middle) 143 c. (Last) BRIDGE

4. DATE OF DEATH: (Month) Aug. (Day) 11, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 3, 1913
9. AGE (In years last birthday): 53 IF UNDER 1 YEAR Months: 8 Days: 8 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Omaha, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Doyle BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Catherine Lamb BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Arnold S. Bridge ADDRESS: Dietrich, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe Rheumatoid Arthritis — 20 yr.
Anemia — 3 yr.

331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10 March, 1963, to 11 Aug, 1967, that I last saw the deceased alive on 11 Aug, 1967, and that death occurred at 458 Am., from the causes and on the date stated above.

23a. SIGNATURE: James H. Bradford, M.D. 489 (Degree or title)
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 8/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Aug. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 8-15-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463
FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

JUN 12 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3730
Local Reg. No. D-307
Reg. Dist. No. 460

BIRTH NO.

REFERRED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: TWIN FALLS 42/ 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): TWIN FALLS
c. LENGTH OF STAY (in this place): 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Twin Falls Clinic 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 340 COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 109 F Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Norma	Sophia	Nelson	Aug 11 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	May 5 1906	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
School Teacher 12		Boise Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Niels Moller-Skjodstrup	Denmark	Eleanore Olesen-Nordby	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-36-6518	X Norma S. Nelson	109 F St Rupert

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

443X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Thrombosis	2 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypertensive Cardiovascular disease	2 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Serous cystadenoma ovary	2 mos

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-19-67	Serous cyst adenoma ovary	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-5, 1967, *to* 8-11, 1967, *that I last saw the deceased alive on* 8-11, 1967, *and that death occurred at* 12 50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
George W. Warner MD 551 (Degree or title)	111 6th Ave E Twin Falls	8/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Aug 11 1967	Rupert Cemetery	Rupert Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-67	Vera Ryals	Robert Walk	E 294

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 6 1967

SEP 3 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3731
Local Reg. No. 0-305
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 31 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY IN (If this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 122 6th Avenue South

3. NAME OF DECEASED (Type or Print)
a. (First) JESSIE
b. (Middle) B. 143
c. (Last) DENNIS

4. DATE OF DEATH (Month) Aug. (Day) 14, (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Dec. 30, 1894

9. AGE (In years last birthday) 72
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Rayborn, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Morefield
BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Emma Barnes
BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Barbara Clark
ADDRESS Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Hypertensive Heart Disease — 20 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-9, 1965, *to* 8-14, 1967, *that I last saw the deceased alive on* 8-14, 1967, *and that death occurred at* 1:10 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE Wm H Henderson MD (Degree or title)

23b. ADDRESS Buhl, Ida

23c. DATE SIGNED 8-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/17/67

24c. NAME OF CEMETERY OR CREMATORY Buhl

24d. LOCATION (City, town, or county) Buhl, (State) Idaho

DATE REC'D BY LOCAL REG. 8-28-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Robert T. Dickard

LICENSE NO. E-312

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3732
Local Reg. No. D-267
Reg. Dist. No. 460

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 260 Lois Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 42
b. COUNTY: T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 260 Lois Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HENRY	HARRISON	SKAGGS	August 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed 2	December 2, 1889	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Miner 07
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dalena, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Skaggs — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Ellen P. Deguire — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 441-01-2251
17. INFORMANT'S OWN SIGNATURE: Frank Skaggs — ADDRESS: Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis — 5 yrs
DUE TO (c): Generalized arteriosclerosis — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-14-67, 19___, *to* 8/14/67, 19___, *that I last saw the deceased alive on* 8-14-67, 19___, *and that death occurred at* 11:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Willard H. Smith M.D.	Twin Falls, Idaho	8/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8/17/67	Granby Cemetery	Granby, Missouri

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-17-67	Pamela J. Johnson	James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-6202

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3733
Local Reg. No. D-286
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH 1-15
a. COUNTY Twin Falls 420
b. CITY OR TOWN Rural Kimberly
c. LENGTH OF STAY (in this place) 15 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Rte 2 (Rural) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN Rural Kimberly
d. STREET ADDRESS (If rural, give location) Route 2, (Rural)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
WILLIAM	MITCHELL	THOMPSON	August	14,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	Sept. 24, 1898	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Joplin, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Thompson	Ohio	Gertrude Gibson	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-18-0500	Frank Thompson	Filer, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Heart attack (Without Medical attention.) — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Did Not Attend m.		

22. *I hereby certify that I attended the deceased from* About *19____, to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at* 4:15 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred D. Maughan 588 Justice of Peace	634 Addison Ave W T. Falls	8/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 17, 1967	Sunset Memorial Pk.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-17-67	Pamela Johnson	William J. Boyd	E-490

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Twin Falls Mortuary

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 27 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3734
Local Reg. No. D-283
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 21 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421 b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
d. STREET ADDRESS (If rural, give location): Route #2

3. NAME OF DECEASED (Type or Print): a. (First) Lee b. (Middle) W. 143 c. (Last) Mathers

4. DATE OF DEATH (Month) (Day) (Year): August 14, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: June 20, 1907

9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: ranch

11. BIRTHPLACE (State or foreign country): Heartwell, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Riley Mathers — BIRTHPLACE: Heartwell, Nebr.

14. MOTHER'S MAIDEN NAME: Georgia Blayney — BIRTHPLACE: Elkhorn, Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-24-4782

17. INFORMANT'S OWN SIGNATURE: Ruby Mathers — ADDRESS: Rt. #2, Kimberly

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio sclerotic Heart Disease — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 14 Aug, 1967, *to* 14 Aug, 1967, *that I last saw the deceased alive on* 14 Aug, 1967, *and that death occurred at* 7:20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James H. Stafford 489 M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 8/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-17-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: [signature]
LICENSE NO.: 343
FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

AUG 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3735
Local Reg. No. 0284
Reg. Dist. No. 460

RECEIVED
AUG 1 8 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Nursing Home 250

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Los Angeles
d. STREET ADDRESS (If rural, give location): 3070 Weldorn Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Fay b. (Middle) C. c. (Last) Daniell

4. DATE OF DEATH (Month) (Day) (Year): August 14, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: July 2, 1885

9. AGE (In years last birthday): 82 | IF UNDER 1 YEAR Months: | Days: | IF UNDER 24 HRS. Hours: | Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Carney, Oklahoma

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Boyer — BIRTHPLACE: Tennessee

14. MOTHER'S MAIDEN NAME: Mollie Bachman — BIRTHPLACE: Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 550-34-7241

17. INFORMANT'S OWN SIGNATURE: Audrey M. Carter — ADDRESS: Twin Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardio vascular disease — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-8, 19 67 *to* 8-13, 19 67 *that I last saw the deceased alive on* 7-10, 19 67 *and that death occurred at* 1 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 460 (Degree or title) — **23b. ADDRESS**: [signature] — **23c. DATE SIGNED**: 8-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): entombment — **24b. DATE**: 8/21/67 — **24c. NAME OF CEMETERY OR CREMATORY**: Woodlawn Park Mausoleum — **24d. LOCATION** (City, town, or county) (State): San Francisco, California

DATE REC'D BY LOCAL REG.: 8-16-67 — **REGISTRAR'S SIGNATURE**: Pamela J. Johnson — **25. EMBALMER**: [signature] — **LICENSE NO.**: 343

FIRM NAME: WHITE MORTUARY Twin Falls, Ida.

Federal Security Agency
United States Public Health Service

Form DH-65021

DUTIES:

DEC 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3736
Local Reg. No. D-302
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 31 1967 2-01 Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 42 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 29 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): R.F.D. # 1

3. NAME OF DECEASED (Type or Print): a. (First) VICKI b. (Middle) MARLENE 143 c. (Last) RICHMOND

4. DATE OF DEATH (Month) (Day) (Year): August 15, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: April 17, 1952

9. AGE (In years last birthday): 15
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: High School

11. BIRTHPLACE (State or foreign country): Twin Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Loy Walden
BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Frieda Brewer
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT'S OWN SIGNATURE: G W Richmond
ADDRESS: RFD # 1 Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH: 12 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Infectious Hepatitis - Subacute — 3 mo
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Perforated Peptic Ulcer — 7 d.

19a. DATE OF OPERATION: 8/8/67

19b. MAJOR FINDINGS OF OPERATION: Perforated Duodenal Ulcer

20. AUTOPSY? YES XX NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 14 July, 1967, *to* 15 Aug, 1967, *that I last saw the deceased alive on* 15 Aug, 1967, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: James A. Stafford 489 (Degree or title) M.D.

23b. ADDRESS: Twin Falls Idaho

23c. DATE SIGNED: 8/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8/18/67

24c. NAME OF CEMETERY OR CREMATORY: Buhl

24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 8-28-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Robert R. Dickard

LICENSE NO.: E-312

FIRM NAME: ALBERTSON & DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

10.994

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3737
Local Reg. No. D-289
Reg. Dist. No. 460

BIRTH NO.

AUG 24 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 600
b. CITY OR TOWN: Twin Falls
(If outside corporate limits, write RURAL and give township) | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION: Twin Falls Clinic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421 b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 883 Blue Lakes Blvd. N.

3. NAME OF DECEASED (Type or Print)
a. (First): Lottie b. (Middle): 144 c. (Last): Sparkman

4. DATE OF DEATH: (Month) August (Day) 15, (Year) 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: April 28, 1896

9. AGE (In years last birthday): 71
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Stigler, Oklahoma

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: J. E. Tiffin
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Mamie Wright
BIRTHPLACE: Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-30-9392

17. INFORMANT'S OWN SIGNATURE: Evert R. Sparkman
ADDRESS: Twin Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2048

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic Lymphatic Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 14 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Diabetes Mellitus — 9 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-30, 1956, *to* 8-15, 1967, *that I last saw the deceased alive on* 8-15, 1967, *and that death occurred at* 4:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: D. M. Gusky 336 (Degree or title)
23b. ADDRESS: Twin Falls Idaho
23c. DATE SIGNED: 8/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Aug. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 8/22/67
REGISTRAR'S SIGNATURE: Vera Ryals
25. EMBALMER:
LICENSE NO.: 343
FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3738
Local Reg. No. D-293
Reg. Dist. No. 460

BIRTH NO.

AUG 24 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls (421)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls (rural) (505)
c. LENGTH OF STAY (in this place): min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hiway 74 5 mi. W.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Pennsylvania
b. COUNTY: Erie (39) (555)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Girard
d. STREET ADDRESS (If rural, give location): 616 Frick Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): ALFRED
c. (Last): VAN SLYKE

4. DATE OF DEATH (Month) (Day) (Year): August 18, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced (4)

8. DATE OF BIRTH: Aug. 12, 1923

9. AGE (In years last birthday): 44
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none (28)

10b. KIND OF BUSINESS OR INDUSTRY: disabled

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James O. VanSlyke
BIRTHPLACE: Penn.

14. MOTHER'S MAIDEN NAME: Alice Joslin
BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT'S OWN SIGNATURE: Personal records of deceased
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Skull fracture, crushed chest
INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto vs. Auto Accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident / Idaho Hgwy. 74 (06)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Twin Falls (13) Twin Falls Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 18 67 6:30 p.m. (2)

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Investigation *to* Only, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 6:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. Thad Scholes M.D. (583) (Degree or title): T.F. Coroner

23b. ADDRESS: 120 Adams, Twin Falls, Ida.

23c. DATE SIGNED: 8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal (3)

24b. DATE: 8-21-1967

24c. NAME OF CEMETERY OR CREMATORY: E. Conneaut Cemetery

24d. LOCATION (City, town, or county) (State): Conneaut, Ohio

DATE REC'D BY LOCAL REG.: 8/22/67

REGISTRAR'S SIGNATURE: Vera Ryals

25. EMBALMER: Dale C. Patterson
LICENSE NO.: E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 24 1967 Bureau of Vital Statistics

State File No. 3739
Local Reg. No. D-292
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42 2-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
STAY (in this place): 4 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazel Del Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 42
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 3312 Shoshone Street East

3. NAME OF DECEASED (Type or Print): a. (First) LILLIAN b. (Middle) BELLE c. (Last) SANDERS

4. DATE OF DEATH (Month) (Day) (Year): August 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Female	White	Widowed 2	April 15, 1885	82		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 01	Own home	Aurora, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Karoly	Unknown	Flora Pierce	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- - - - - - - - -	519-28-5681 D	Flora E Wagner	Twin Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — 8 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
- - - -	- - - - - - - - -

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 24 1967 Bureau of Vital Statistics

State File No. 3740
Local Reg. No. D-291
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY IN THIS PLACE: min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 490
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls (Rural
d. STREET ADDRESS (If rural, give location): Rt. #1 So. Washington

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	RILEY	DAVIS	August 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Jan. 29, 1905	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 06	Feed mill	Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William R. Davis	Arkansas	Ida Kesterson	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- - - - - -	494-10-1450	x Anna Lisa Davis	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull Fracture, Crushed Chest — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Crushed by falling elevator
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Elevator shaft	Twin Falls 13	Twin Falls	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒	NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
8	18	67	10:30 a.m.			

22. *I hereby certify that I attended the deceased from* Investigation *to* Only, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Thad Scholes M.D. 583 Twin Falls Coroner 4	120 Adams Twin Falls, Ida.	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	8-22-67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/22/67	Vera Ryals	Dale P. Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 7 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 10 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

NOV 3 1980

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3741
Local Reg. No. D-290
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED AUG 24 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Ada 01
c. CITY OR TOWN Boise
d. STREET ADDRESS (If rural, give location) 7701 Ustick Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	M.	Tuttle	August 18th 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 26, 1915	52				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction Equip. Operator 11
10b. KIND OF BUSINESS OR INDUSTRY 57
11. BIRTHPLACE (State or foreign country) Redfield South Dakota
12. CITIZEN OF WHAT COUNTRY? Us

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James O. Tuttle	Unknown	Rose Pratt	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 507-05-4290
17. INFORMANT'S OWN SIGNATURE * Edna A. Tuttle ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4291 Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 12hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 2yrs+
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 15 Aug, 1967, *to* 18 Aug, 1967, *that I last saw the deceased alive on* 18 Aug, 1967, *and that death occurred at* 9:35P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James W. Gaylord M.D. 489	Twin Falls, Idaho	8.19.67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial-Removal	8.19.67	Dry Creek Cem.	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8/22/67	Vera Ryals		343

FIRM NAME White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 31 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 7 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 23 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3742
Local Reg. No. D-296
Reg. Dist. No. H-60

67-9277
BIRTH NO.

RECEIVED
AUG 24 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 227 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (In this place): 143
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 412 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hansen
d. STREET ADDRESS (If rural, give location): R.R.# 1

3. NAME OF DECEASED (Type or Print): a. (First) THOMAS b. (Middle) c. (Last) CHAVEZ

4. DATE OF DEATH: (Month) (Day) (Year) 8 - 19 - 1967

5. SEX: Male

6. COLOR OR RACE: Mexican

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 8-19-1967

9. AGE (In years last birthday): 0 | IF UNDER 1 YEAR Months: 0 | Days: 0 | IF UNDER 24 HRS. Hours: 1 | Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Twin Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Chavez
BIRTHPLACE: Walsenburg Colo.

14. MOTHER'S MAIDEN NAME: Mary S. Morales
BIRTHPLACE: New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Henry Chavez
R.R.# 1 Hansen, Idaho
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7625

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Neonatal atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c) Pelvic infection

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8/19/ , 1967 , *to* 8/19/ , 1967 , *that I last saw the deceased alive on* 8-19, 1967, *and that death occurred at* 9:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE: W N Kramer 293 (Degree or title) M.D.

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8-22-67

24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-22-67

REGISTRAR'S SIGNATURE: Vera Ryals

25. EMBALMER: Paul D. Reynolds

LICENSE NO.: E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3743
Local Reg. No. 10-308
Reg. Dist. No. 460

RECEIVED AUG 31 1967 Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 197
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) Birth 17 yeaars
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence--R.F.D. # 1 0

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
STATE Idaho 420 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) R.F.D. # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
RUTH	ANN	KULIK	Aug. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	Sept. 14, 1959	7				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child 02		Twin Falls, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Kulik	Buhl, Idaho	Dolly Miller	Lamar, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		--	Ruby C Kulik	RFD # 1 Buhl, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 493X Pneumonia — INTERVAL BETWEEN ONSET AND DEATH hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGsignificant CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mental defective — Burth

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* — , 19— , *to* — , 19— , *that I last saw the deceased alive on* — , 19— , *and that death occurred at* 1:000 M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD 118	122 9th Ave No Buhl Idaho	8-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8/22/67	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-30-67	Pamela J. Johnson	Robert H. Dickard	E-312

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 16 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3744
Local Reg. No. D-227
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 42 / Twin Falls 007

b. CITY OR TOWN (If outside corporate limits, write RURAL and township): Twin Falls

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blue Front Bar 221 Shoshone St. S. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 42 / b. COUNTY: Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

d. STREET ADDRESS (If rural, give location): Labor Camp

3. NAME OF DECEASED (Type or Print): a. (First) Marcos b. (Middle) c. (Last) Jasso, Jr.

4. DATE OF DEATH: (Month) (Day) (Year) August 20, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Jan. 1, 1940

9. AGE (In years last birthday): 27 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): San Yonaicio, Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Marcos Jasso — BIRTHPLACE: Mexico

14. MOTHER'S MAIDEN NAME: Angelita Garsa — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 453-60-0278

17. INFORMANT'S OWN SIGNATURE: Lidivina E Jasso — ADDRESS: Twin Falls

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 98 X Massive Pulmonary Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Shotgun wound to chest

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Homicide 3

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Blue Front Bar TF 52

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Twin Falls 13 Twin Falls 42 / Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8 20 67 8:30 p.m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?: Shot with 12 gauge shotgun at close range.

22. *I hereby certify that I attended the deceased from* Investigation Only, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: H. Thad Scholes MD 583 (Degree or title) TF Coroner 4

23b. ADDRESS: 120 Adams, Twin Falls, Ida.

23c. DATE SIGNED: 8-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Aug. 26, 1967

24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-25-67

REGISTRAR'S SIGNATURE: Vera Ryals

25. EMBALMER: [signature]

LICENSE NO.: 343

FIRM NAME: WHITE MORTUARY, Twin Falls, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3745
Local Reg. No. D-313
Reg. Dist. No. 460

BIRTH NO.

SEP 11 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 2 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 83316
d. STREET ADDRESS (If rural, give location) R.F.D. # 4

3. NAME OF DECEASED (Type or Print)
a. (First) ANNA
b. (Middle) E.
c. (Last) KOCH

4. DATE OF DEATH (Month) Aug. (Day) 20, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Sept. 20, 1881
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jacob Thiel — BIRTHPLACE Russia
14. MOTHER'S MAIDEN NAME Elizabeth Stromberger — BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-54-0688T
17. INFORMANT'S OWN SIGNATURE Roy F. Koch — ADDRESS RFD # 4 Buhl, Idaho 83316

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: sev yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) Diabetes Mellitus — 5 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Coma " " — 2 wks.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-12, 1960, *to* 8-20, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 6:10 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE Vern H. Anderson MD 011 (Degree or title)
23b. ADDRESS Buhl, Idaho 83316
23c. DATE SIGNED 9/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/23/67
24c. NAME OF CEMETERY OR CREMATORY Buhl
24d. LOCATION (City, town, or county) Buhl, (State) Idaho

DATE REC'D BY LOCAL REG. 9-7-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER George Farmer
LICENSE NO. E-480

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 8 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3746
Local Reg. No. D-300
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 8 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Nursing Home 250

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lillie	May	Wrinkle	August 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	Feb. 9, 1891	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Crawford, Nebr.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no	518-16-7997	Maxwell D Harvey	Kimberly, Idaho

4500

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis Generalized — 15 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19 64, *to* 20 Aug, 19 67, *that I last saw the deceased alive on* 20 Aug, 19 67, *and that death occurred at* 9:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Ellis Knight M.D.		Kimberly, Idaho	8-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8.24.67	Sunset Memorial Park Cem.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-67	Vera Ryals		343

FIRM NAME: WHITE MORTUARY Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED AUG 24 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3747
Local Reg. No. D-295
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 645 Quincy Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 645 Quincy Street

3. NAME OF DECEASED (Type or Print)
a. (First) Violetta
b. (Middle) E.
c. (Last) Cannon

4. DATE OF DEATH (Month) (Day) (Year) August 21, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH December 13, 1876
9. AGE (In years last birthday) 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Springville, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Georgr Gabbitas — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME unknown — BIRTHPLACE Mansfield, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-60-3076
17. INFORMANT'S OWN SIGNATURE Reno, Nevada, ADDRESS [illegible]

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arterio sclerosis — 15 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Cerebral Embolism — 1 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1960, to 8/21/, 1967, that I last saw the deceased alive on _____, 19__, and that death occurred at 4:30a. m., from the causes and on the date stated above.*

23a. SIGNATURE George C Halley 198 (Degree or title) M.D. 1
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 8/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/23/67
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. 8/22/67
REGISTRAR'S SIGNATURE Vera Ryals
25. EMBALMER Paul D. Reynolds — Paul D. Reynolds
LICENSE NO. E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Amended August 1, 1968

Certificate of Death

STATE OF IDAHO

State File No. 3748
Local Reg. No. D-299
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazel Del Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 138 Walnut St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Harry	Edward	Ryan	August 21, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Nov. 8, 1886	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Representative	Hardward Suppliers	Parker, South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Ryan	Clayton County, Iowa	Bridget McDermott	Noutack, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-09-7984	John C. Ryan	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-6, 1957, *to* 8-21, 1967, *that I last saw the deceased alive on* 8-21-, 1967, *and that death occurred at* 12:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. F. Wurster, M.D.	204 4th Ave. East, Twin Falls	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug 24, 1967	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-67	Vera Ryals	Hugh Phillips	343

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: White Mortuary, Twin Falls, Ida.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
JUL 25 1968
Bureau of Vital Statistics

State of IDAHO } ss.
County of Twin Falls }

Certificate No. 67-3748

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Harry E. Ryan (Name on Original Certificate) who died (Was Born or Died) on August 21, 1967 (Date of Event)
in Twin Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Certificate of Birth (Bible Record, Insurance Policy, Etc.) prepared on Feb. 28, 1942 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#3 Name of Deceased	Harry E. Ryan	Harry Edward Ryan
#11 Birthplace	Sioux Falls, So.Dakota	Parker, S. Dak.
#13 & #14 Birthplace Parents	Ireland	(Father: Clayton County, Iowa; **
#14 Mother's Maiden Name	Margaret Unknown	Bridget McDermott

Subscribed and sworn to before me this 10th day of July, 1968.

H C Blandford

Notary Public, residing at Twin Falls, Idaho.
My commission expires Nov. 1, 1969.
(Seal)

Signed
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

695 Sunrise Blvd. N., Twin Falls, Idaho.
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of IDAHO } ss.
County of Twin Falls }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 10th day of July, 1968.

H C Blandford

Notary Public, residing at Twin Falls, Idaho.
My commission expires Nov. 1, 1969.
(Seal)

Signed Julia Ann Ryan Blandford
(Signature of Any Credible Person)

141 Juniper St. N., Twin Falls, Idaho.
(Street Address, City, State)

FORM DH 60-155 **Mother: Noutack, Ohio)

L. 7-3-68 M

Affidavit to Correct or Amend a Original Certificate of Birth or Death

State of Idaho } ss.
County of Twin Falls

Certificate No. [illegible]

Date [illegible]

The undersigned does solemnly swear [illegible]

[illegible]

true form [illegible] Certificate of Birth [illegible]

[illegible]

Name [illegible] Date [illegible]

[illegible] Deceased [illegible]

[illegible] Clayton County, Iowa; **

[illegible] Bridget Ackermott

[illegible] Twin Falls, Idaho.

[illegible] Nov. 1, [illegible]

Sunrise Blvd. N., Twin Falls, Idaho.

[illegible]

Stat[illegible] O

[illegible] Twin Falls

[illegible] that they

[illegible] Twin Falls, Idaho.

[illegible] Nov. 1, [illegible]

[illegible] St. N., Twin Falls, Idaho.

**Mother: Noutach, Ohio)

Certificate of Death

STATE OF IDAHO

State File No. 3748
Local Reg. No. D-3748
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Hazel Del Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 421 Twin Falls
c. CITY OR TOWN Twin Falls
d. STREET ADDRESS (If rural, give location) 138 Walnut St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Harry	E.	Ryan	August 21, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed 2	Nov. 8, 1886	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales Representative	Hardware Suppliers	Sioux Falls, South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Ryan	Ireland	Margaret unknown	Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-09-7984	[signature]	Twin Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary Arteriosclerosis — unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3-6, 1957, *to* 8-21, 1967, *that I last saw the deceased alive on* 8-21, 1967, *and that death occurred at* 12:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	204 4th Ave. East Twin Falls, Idaho 83301	8-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug. 24, 1967	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-25-67	Vera Ryals	[signature]	343

FIRM NAME: WHITE MORTUARY, Twin Falls, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 6 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 12 1977

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3749
Local Reg. No. D-398
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 29 1967 Bureau of Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN Twin Falls
Inside limits of city or town (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 501 3rd Ave. N.

3. NAME OF DECEASED (Type or Print)
a. (First) Ida
b. (Middle) Ione 143
c. (Last) Allen

4. DATE OF DEATH (Month) (Day) (Year) August 23, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH Feb. 19, 1898

9. AGE (In years last birthday) 69
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) school teacher 12

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Manchester, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John T. Allen
BIRTHPLACE Canada

14. MOTHER'S MAIDEN NAME Mary E. Smith
BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-46-4712

17. INFORMANT'S OWN SIGNATURE Gertrude E. Allen
ADDRESS Twin Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1208

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of breast — 3 1/2 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Bronchial asthma
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-25-64, 19___, *to* 8-23, 1967, *that I last saw the deceased alive on* 8-23, 1967, *and that death occurred at* 945 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Craig E. Brown 061 (Degree or title) MD
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 8-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Aug. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) Twin Falls, (State) Idaho

DATE REC'D BY LOCAL REG. 8-25-67
REGISTRAR'S SIGNATURE Vera Ryals

25. EMBALMER
LICENSE NO. 343

FIRM NAME: WHITE MORTUARY, Twin Falls, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3750
Local Reg. No. 3-303
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 31 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 401 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 305 4th Ave. N.

3. NAME OF DECEASED (Type or Print) a. (First) Carrie b. (Middle) Ann 143 c. (Last) Stimson

4. DATE OF DEATH (Month) (Day) (Year) August 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	Aug. 27, 1887	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Glenwood, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edwin Durk BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Laverna St.Claire BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 517-36-3070
17. INFORMANT'S OWN SIGNATURE & Mary Stimson ADDRESS Twin Falls

4200

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured abdominal aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 5 yrs
DUE TO (c) General arteriosclerosis — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 19 1957, *to* August 23 1967, *that I last saw the deceased alive on* August 23 1967, *and that death occurred at* 8:45a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Willard H. Clark MD	Twin Falls	8-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	August 26, 1967	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-28-67	Pamela J. Johnson	Wayne Dalton	343

FIRM NAME: WHITE MORTUARY, Twin Falls, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: SEP 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3751
Local Reg. No. 0-306
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 31 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
LENGTH OF STAY (in this place) 43
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42
b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 640 Filer Avenue West

3. NAME OF DECEASED (Type or Print)
a. (First) EDNA
b. (Middle) QUALLS
c. (Last) SEITZ

4. DATE OF DEATH (Month) (Day) (Year) August 26, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 27, 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rudd, Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: John Roberts — BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Louise Dunlap — BIRTHPLACE: Tenn.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. MA 842 511
17. INFORMANT'S OWN SIGNATURE C T Qualls — ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 72 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Vascular disease — Years
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-25-66 *to* 8/26/67, 19 67, *that I last saw the deceased alive on* 8-26, 1967, *and that death occurred at* 4:43 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE H. Thad Scholes (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 8-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/28/67
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 8-29-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER James C. Reynolds — James C. Reynolds
LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-65021

DUTIES:

SEP 30 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3752
Local Reg. No. D-312
Reg. Dist. No. 460

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY IN THIS PLACE (If dead on arrival, or if not in hospital or institution, give length of residence): 303 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 421 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 219 N. Washington

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
RILLER	JANE	WEBB	Aug.	26,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed 2	Aug. 1, 1874	93	0	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Hartville, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Casey	Unknown	Julia Martin	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	518-60-2635 J1	X Mrs H. W. Riller	219 N. Washington Twin Falls, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility — Old age — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis
DUE TO (c) Heart Failure — Mc

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-17- , 1967, *to* 8-26 , 1967, *that I last saw the deceased alive on* 8-26 , 1967, *and that death occurred at* 4 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Willard R. — 4/7	Twin Falls, Ida.	9-5-1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8-26-1967	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-7-67	Pamela J. Johnson	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-43021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 39-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Glenn A. Hoss -

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3753
Local Reg. No. D-311
Reg. Dist. No. 460

BIRTH NO.

SEP 5 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem Hosp. 743

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) Box 341

3. NAME OF DECEASED (Type or Print)
a. (First) Rose
b. (Middle) May
c. (Last) Denney

4. DATE OF DEATH (Month) (Day) (Year) Aug. 27, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan. 29, 1917
9. AGE (In years last birthday) 50 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Osage City, Kansas
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Isaac Crable — BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Myrtle Harrison — BIRTHPLACE Kansas.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-58-3626
17. INFORMANT'S OWN SIGNATURE X Raymond C Denney — ADDRESS Box. 341 Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

584X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis of the liver. — INTERVAL BETWEEN ONSET AND DEATH: Approx. 6 Mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of the gall bladder. — Approx. 1 Yr.
DUE TO (c) Gall stones — Approx. 10 Yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 7-17-67
19b. MAJOR FINDINGS OF OPERATION Carcinoma of gall bladder with metastases to the liver.
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to* Aug. 27, 1967, *that I last saw the deceased alive on* Aug. 27, 1967, *and that death occurred at* 7:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Glenn A. Hoss, M.D. 246 (Degree or title)
23b. ADDRESS 1221 Lynwood Mall Twin Falls, Idaho
23c. DATE SIGNED 8-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8-31-1967
24c. NAME OF CEMETERY OR CREMATORY Hagerman Cemetery
24d. LOCATION (City, town, or county) Hagerman (State) Idaho

DATE REC'D BY LOCAL REG. 9-1-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER Robert S Meyer
LICENSE NO. E-424
FIRM NAME: Thompson Chapel--Gooding, Idah

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 18 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3754
Local Reg. No. D-37
Reg. Dist. No. 46

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 83316
c. LENGTH OF STAY (in this place) 3 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 83316
d. STREET ADDRESS (If rural, give location) 122 8th Ave. South

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) A. c. (Last) LEADER

4. DATE OF DEATH (Month) (Day) (Year) Aug. 27, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Sept. 6, 1880

9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Phillipsburg, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John W. Bennett — BIRTHPLACE Indiana

14. MOTHER'S MAIDEN NAME Ellen Burnett — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-24-2712A

17. INFORMANT'S OWN SIGNATURE Doris P Carter - Twin Falls 83301 — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Hypertensive Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH several yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Left Hemiplegia — 3 months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-5 *19* 65, *to* 8-27 *, 19* 67, *that I last saw the deceased alive on* _____ *19* ___, *and that death occurred at* 3:30 a *m., from the causes and on the date stated above.*

23a. SIGNATURE Vern H Anderson MD 01 (Degree or title)

23b. ADDRESS Buhl, Idaho 83316

23c. DATE SIGNED 9/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/30/67

24c. NAME OF CEMETERY OR CREMATORY Buhl

24d. LOCATION (City, town, or county) Buhl, (State) Idaho

DATE REC'D BY LOCAL REG. 9-7-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER George Tanner — **LICENSE NO.** E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3755
Local Reg. No. D-307
Reg. Dist. No. 460

BIRTH NO.

RECEIVED AUG 31 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 22 Twin Falls
b. CITY OR TOWN Twin Falls
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION Hazel Del Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 43
b. COUNTY Twin Falls 430
c. CITY OR TOWN Filer
d. STREET ADDRESS (If rural, give location) 909 Yakima

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) CURRY c. (Last) HART

4. DATE OF DEATH (Month) (Day) (Year) August 27, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH February 17, 1891
9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Farmington, Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George R. Hart BIRTHPLACE Minnesota
14. MOTHER'S MAIDEN NAME Edith Curry BIRTHPLACE Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-40-4631
17. INFORMANT'S OWN SIGNATURE Irene Hart ADDRESS Filer, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Benign Prostatic Hypertrophy, Parkinsons Disease, Cerebral Arterio Sclerosis, Auricular fibrillation, Heart Failures

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/27, 19 66, *to* 8/28, 19 67, *that I last saw the deceased alive on* 8/26, 19 67, *and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Roy O. Shaub M.D. 466 (Degree or title)
23b. ADDRESS 676 Shoup Ave W. Twin Falls Idaho
23c. DATE SIGNED 8/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. 8-29-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER William J. Page
LICENSE NO. E-490

FIRM NAME: Twin Falls Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 1 1 2015 X

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3756
Local Reg. No. D 309
Reg. Dist. No. 460

Amended 9-27-67

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 42 Twin Falls

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 42

b. COUNTY T.Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

d. STREET ADDRESS (If rural, give location) 363 Maurice Street Nth.

3. NAME OF DECEASED (Type or Print)

a. (First) JUNIOR

b. (Middle) HEAP

c. (Last) STEADMAN

4. DATE OF DEATH (Month) (Day) (Year) August 28, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH August 31, 1925

9. AGE (In years last birthday) 41

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician 21

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Freedom, Wyoming

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George A. Steadman

BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Sara Heap

BIRTHPLACE Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes

(If yes, give war or dates of service) W.W. #2 4

16. SOCIAL SECURITY NO. 529-24-6719

17. INFORMANT'S OWN SIGNATURE Mrs Shirlene Steadman

ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of Papillary Muscle — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myocardial infarction

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* 8/28/, 19 67, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 6:50p. m., *from the causes and on the date stated above.*

23a. SIGNATURE A. W. Kendall 277 (Degree or title) M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 9/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/1/67

24c. NAME OF CEMETERY OR CREMATORY West Jordan Cemetery

24d. LOCATION (City, town, or county) (State) West Jordan, Utah

DATE REC'D BY LOCAL REG. 9-25-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. FUNERAL DIRECTOR Paul D. Reynolds

ADDRESS Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DPH-46021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of Paul D.Reynolds Lic. No. E-495 at Twin Falls on 8/28/67

ADDITIONAL REMARKS by Physician

Certificate of Death

RECEIVED SEP 5 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 3756
Local Reg. No. 9-309
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 363 Maurice St. Nth

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	JUNIOR	HEAP	STEADMAN		8	28	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	8-31-1967	41				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrician for U.P.R.R.
10b. KIND OF BUSINESS OR INDUSTRY: Electrician
11. BIRTHPLACE (State or foreign country): Freedom, Wyoming
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George A. Steadman
BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Sarah Heap
BIRTHPLACE: Wyoming
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W.# 2
16. SOCIAL SECURITY NO.: 529-34-6719
17. INFORMANT'S OWN SIGNATURE: Mrs Sherline Steadman, ADDRESS: Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured papillary muscle heart — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Acute myocardial infarct

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* 8-28, 1967, *that I last saw the deceased alive on* 8-28, 1967, *and that death occurred at* 6:50p m., *from the causes and on the date stated above.*

23a. SIGNATURE: A. W. Kendall (Degree or title): M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Trans-Burial
24b. DATE: 9-1-1967
24c. NAME OF CEMETERY OR CREMATORY: West Jordan Cemetery
24d. LOCATION (City, town, or county) (State): Salt Lake County, Utah

DATE REC'D BY LOCAL REG.: 8-31-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. FUNERAL DIRECTOR: Paul D. Reynolds, ADDRESS: E-495
Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DPH-40001

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

SEP 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 11 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

JUN 19 1991

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

State File No. 3757
Local Reg. No. D-310
Reg. Dist. No. 460

RECEIVED STATE OF IDAHO
SEP 5 1967
Bureau of Vital Statistics

BIRTH NO. 143

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (If hospital or institution)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) R.R.# 2 83301

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	JAMES	EARL	LOCKARD		8	28	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	3-22-1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Farmer 04	Farming	Jamestown, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Enos Lockard	Jackson, Ohio	Effie Getchall	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	494-18-6230	Kimberly D. Lockard	Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Asphyxiation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis of Aorta c 2 previous strokes

DUE TO (c) Diabetes Mellitus Carcinoma of Lip removed Cataracts.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 15 min 4 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1967, *to* 8/29, 1967, *that I last saw the deceased alive on* 8/29, 1967, *and that death occurred at* 2:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ray O. Shaw B 466	M.D.	Twin Falls, Idaho	8/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-2-1967	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-1-67	Pamela J. Johnson	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-630.1

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED AUG 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3758
Local Reg. No. 18
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 030 Valley 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) rural McCall
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 20 mi creek-north McCall 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 020 Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Meadows
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) HARRY b. (Middle) A. c. (Last) THOMAS

4. DATE OF DEATH (Month) (Day) (Year) August 1, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Feb. 26, 1904

9. AGE (In years last birthday) 63 | If UNDER 1 YEAR Months | Days | If UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logger 17

10b. KIND OF BUSINESS OR INDUSTRY J. I. Morgan Co

11. BIRTHPLACE (State or foreign country) Magazine, Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Thomas BIRTHPLACE Arkansas

14. MOTHER'S MAIDEN NAME Lora Catherine Bass BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-16-6962

17. INFORMANT'S OWN SIGNATURE Dora F Thomas ADDRESS New Meadows, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

9208

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MASSIVE CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) INTRA THORACIC INJURIES
DUE TO (c) HEAD INJURIES & CRUSHED CHEST

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* NONE

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) ACCIDENT

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) WOODS 09

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 ADAMS IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 8-1-67 8:30 A.M.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? STRUCK BY FALLING SNAG

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 8:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 391 Edward S Hokett M.D.

23b. ADDRESS McCALL, IDAHO

23c. DATE SIGNED 8-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 4, 1967

24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery

24d. LOCATION (City, town, or county) Boise, (State) Idaho

DATE REC'D BY LOCAL REG. Aug-9-1967

REGISTRAR'S SIGNATURE Myrtle M Gardner

25. EMBALMER Burton E Walker

LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-6021

AUG 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3759
Local Reg. No. 20
Reg. Dist. No. 310

RECEIVED
AUG 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley 101
b. CITY OR TOWN McCall
c. LENGTH OF STAY (in this place) 15 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Lakes Nursing Home 327

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 250
b. COUNTY Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Whitebird
d. STREET ADDRESS (If rural, give location) Whitebird, Idaho Joseph Plains

3. NAME OF DECEASED (Type or Print)
a. (First) LEO
b. (Middle) L
c. (Last) BRUST

4. DATE OF DEATH (Month) (Day) (Year) August 6, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH June 5, 1892

9. AGE (In years last birthday) 75
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher-Butcher 04

10b. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Cottonwood, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Adam Brust
BIRTHPLACE Ohio

14. MOTHER'S MAIDEN NAME Elizabeth Unknown
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. Yes 518-05-4831

17. INFORMANT'S OWN SIGNATURE Jack Brust Jr
ADDRESS Whitebird, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3347

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Complete stroke syndrome — 2 years

DUE TO (c) Cerebral arteriosclerosis — 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6-, 1965, *to* 8-6-, 1967, *that I last saw the deceased alive on* 8-5-, 1967, *and that death occurred at* 6:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Wayne F. Allen 886 (Degree or title) MD

23b. ADDRESS McCall Idaho

23c. DATE SIGNED 8-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 8/9/67

24c. NAME OF CEMETERY OR CREMATORY Prairieview

24d. LOCATION (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. Aug-15-1967

REGISTRAR'S SIGNATURE Myrtle Gardner

25. EMBALMER Robert R Hansen

LICENSE NO. E 433

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3760
Local Reg. No. 21
Reg. Dist. No. 316

BIRTH NO.

RECEIVED AUG 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 430 Valley 002
b. CITY OR TOWN McCall
c. LENGTH OF STAY IN THIS PLACE 2 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 001 Ada
c. CITY OR TOWN Boise
d. STREET ADDRESS (If rural, give location) 2815 Alamo Road

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Harlan	Goodwin	Formo	August 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	July 1, 1920	47				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Health Engr. 08	State of Idaho	Maynard, Minn.	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Emil O. Formo	Norway	Huldah Nelson	Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 2	469-22-0015	Marjorie E. Formo	Boise

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 20 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-18, 1967, *to* 8-18, 1967, *that I last saw the deceased alive on* 8-18, 1967, *and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wayne F. Allen M.D. 006	McCall Idaho	8-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 21, 1967	Syringa Gardens	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Aug 25 1967	Myrtle A. Gardner	Burton C Walker	E-386

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3761
Local Reg. No. 22
Reg. Dist. No. 910

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley — SEP 5 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bureau of Vital Statistics
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 3miles No. Smith Ferry

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY 231 Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Monnted Route

3. NAME OF DECEASED (Type or Print) — a. (First) Herman — b. (Middle) Edgar — c. (Last) Lappens

4. DATE OF DEATH (Month) (Day) (Year) Aug. 21, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH May 1, 1909

9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 06

10b. KIND OF BUSINESS OR INDUSTRY lumber

11. BIRTHPLACE (State or foreign country) Naper, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Pete Lappens — BIRTHPLACE Wisconsin

14. MOTHER'S MAIDEN NAME Bess Duvall — BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 561 03 3109

17. INFORMANT'S OWN SIGNATURE X Edith Lappens — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 9108 CRUSHED CHEST — INTERVAL BETWEEN ONSET AND DEATH 30 MINS

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) ACCIDENT 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 09

21c. (CITY, TOWN, OR TOWNSHIP) SMITH FERRY (COUNTY) VALLEY 430 (STATE) IDA.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Aug. 21 67 8 a.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? STRUCK BY TRUCK

22. *I hereby certify that I attended the deceased from* Aug 20 _____, 19___, *that I last saw the deceased alive on* Aug 20, *and that death occurred at* 8A *m., from the causes and on the date stated above.*

23a. SIGNATURE John T. Moore 376 (Degree or title) MD

23b. ADDRESS Cascade

23c. DATE SIGNED 8/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Aug. 24, 1967

24c. NAME OF CEMETERY OR CREMATORY Emmett

24d. LOCATION (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. Aug-31-1967

REGISTRAR'S SIGNATURE Maude M. Gardner

25. EMBALMER Glenn W Beatty — LICENSE NO. E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 20 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 9 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 12 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3762
Local Reg. No. 23
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley County Hospital 307
b. CITY OR TOWN McCall
LENGTH OF STAY (in this place) 1 week

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Ada
c. CITY OR TOWN Boise
d. STREET ADDRESS (If rural, give location) Manitou Hotel

d. FULL NAME OF HOSPITAL OR INSTITUTION McCall Memorial Hospital

3. NAME OF DECEASED (Type or Print) 209
a. (First) KATHERINE b. (Middle) MARY c. (Last) RIETZ

4. DATE OF DEATH (Month) August (Day) 26, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 5, 1886
9. AGE (In years last birthday) 81 | If under 1 year: Months | Days | If under a day: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Little Rock, Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gonder BIRTHPLACE France
14. MOTHER'S MAIDEN NAME Krantz BIRTHPLACE Berlin, Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 347-16-5913A
17. INFORMANT'S OWN SIGNATURE Personal records ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHIAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 4 DAYS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) GENERALIZED ARTERIO SCLEROSIS — YEARS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-16, 19 67, to 8-26, 19 67, *that I last saw the deceased alive on* 8-26, 19 67, *and that death occurred at* 11:00 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 391 Ronald S. Mokes M.D.
23b. ADDRESS McCall, Idaho
23c. DATE SIGNED 9-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Aug 28, 1967
24c. NAME OF CEMETERY OR CREMATORY McCall Cemetery
24d. LOCATION (City, town, or county) McCall (State) Idaho

DATE REC'D BY LOCAL REG. Sept-7-1967
REGISTRAR'S SIGNATURE Myrtle A. Gardner
25. EMBALMER Burton C. Walker
LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-6902I

APR 2 1 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3763
Local Reg. No. 13
Reg. Dist. No. 320

BIRTH NO.

RECEIVED
AUG 23 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 241 Washington
b. CITY OR TOWN: Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 441
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): Rte. #1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Malcolm	J.	Johnson	8	5	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	caucasian	married 3	6/23/1896	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fireman 10	Union Pacific RR	Hemingford, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Moses Johnson	Illinois	Emma Endsley	N. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
			Mrs M J Johnson	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

350X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Parkinson's Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-14-, 1967, *to* 8-5-, 1967, *that I last saw the deceased alive on* 8-5-, 1967, *and that death occurred at* 11:38 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. D. McGrath MD	Weiser, Idaho	8/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	8/8/67	Hillcrest cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-8-67	K. Dale Thomson	Marshall L. Dickerson Jr.	E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 2 1982

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3764
Local Reg. No. 11
Reg. Dist. No. 320

RECEIVED
AUG 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 441 Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First) Haruichi
b. (Middle)
c. (Last) Sakoi

4. DATE OF DEATH (Month) 8 (Day) 10 (Year) 1967

5. SEX male
6. COLOR OR RACE Japanese
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH 4/12/1893
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer 04
10b. KIND OF BUSINESS OR INDUSTRY farming
11. BIRTHPLACE (State or foreign country) Hiroshima, Japan
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ------ BIRTHPLACE Japan
14. MOTHER'S MAIDEN NAME ------- BIRTHPLACE Japan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mae Sakoi ADDRESS Weiser, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Lung — INTERVAL BETWEEN ONSET AND DEATH 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-29-67, 19__, *to* 7-14-67, 19__, *that I last saw the deceased alive on* 8-10-67, 19__, *and that death occurred at* 8:05 A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 667 (Degree or title)
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED 8/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 8/14/1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. 8/11/67
REGISTRAR'S SIGNATURE R. Dave Thomason
25. EMBALMER Marshall Jackerson Jr.
LICENSE NO. E 464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

JUL 2 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 0 2 2000

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3765
Local Reg. No. 15
Reg. Dist. No. 320

Certificate of Death

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 30 Miles N.E.Big Flat Area 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 250
b. COUNTY Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pollock
d. STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print)
a. (First) CLAUDE
b. (Middle) P.
c. (Last) LINER

4. DATE OF DEATH (Month) 8 (Day) 22 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) ---- 0
8. DATE OF BIRTH April 15,1908
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheep herder 04
10b. KIND OF BUSINESS OR INDUSTRY Sheep
11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME ---- BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME ---- BIRTHPLACE ----
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 411-01-2520
17. INFORMANT'S OWN SIGNATURE Mrs Mildred A Thomas ADDRESS Pollock, I.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subject walked into a ranch house after riding many miles and apparently died of a heart attack in the presence of several witnesses. To the best of my knowledge & belief, subject died of natural causes.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Dorothy L Davis 588 (Degree or title) Justice of Peace 5
23b. ADDRESS Cambridge, Idaho
23c. DATE SIGNED 9-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal Bur
24b. DATE 8/26/67
24c. NAME OF CEMETERY OR CREMATORY Riggins Cemetery
24d. LOCATION (City, town, or county) Riggins (State) Idaho

DATE REC'D BY LOCAL REG. 9-3-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Marshall S. Dickerson Jr.
LICENSE NO. E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3766
Local Reg. No. 14
Reg. Dist. No. 320

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
DURATION OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home, E. Commercial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 441 Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) E. Commercial

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	ALBERT	VERNON	ALBERTSON		8	26	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Divorced 4	June 8, 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Farm & Construction	Caldwell, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert H. Albertson	LaSalle, Ill.	Adelene Maude Brown	Palistine, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Frank D. Albertson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Self inflicted gun shot wound	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Suicide 2	Home. 01	Weiser	441 Washington	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
8	26	67	2:45 p	2	Self inflicted bullet wound.

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dorothy A. Neuhoff 578	Justice of Peace 5	Weiser, Idaho	8/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	8/28/1967	Hillcrest Cemetery	Weiser	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-26-67	K. Dawn Thomason	Marshall S. Dickerson Jr.	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

STATE OF IDAHO

State File No. 3767
Local Reg. No. 130
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
SEP 6 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 010 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. # 2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 13 Idaho
b. COUNTY 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
d. STREET ADDRESS (If rural, give location) Rt. # 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Larry	Edwin	Doramus	Sept. 1, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married /	Oct. 26, 1954	12				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 29	----------	Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elmer H. Doramus	Oklahoma	Iola Hunter	Carey, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	+ Mrs Elmer Doramus	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Spasm — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Shock or fright
DUE TO (c) Bolt of lightning

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident /	home 01	Meridian 13	Ada 011	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
9/1/67 9:15 p.m. 2		lightning strike near house

22. *I hereby certify that I attended the deceased from* as coroner only, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 915 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] 583 (Degree or title) Coroner 4	3720 Meadow Dr., Boise, Ida.	9/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial /	9/6/67	Syringa Gardens Cem.	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-6-67	Myrtle Palmer By Helen Olsen	[signature]	E 422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 17 2017

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Myers
200 E Bannock

67-8279
BIRTH NO.

RECEIVED
SEP 7 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3768
Local Reg. No. 490
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Saint Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 102 Jackson

3. NAME OF DECEASED (Type or Print)
a. (First): SCOTT
b. (Middle): DOUGLAS
c. (Last): LEIBY

4. DATE OF DEATH (Month) (Day) (Year): (9 1 1967)

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Baby 1
8. DATE OF BIRTH: 8/29/67
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 0 Days 2½ IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Eugene O. Leiby
BIRTHPLACE: Freeport, Illinois
14. MOTHER'S MAIDEN NAME: Sandra Kay Rigney
BIRTHPLACE: Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Eugene Leiby
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7545

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Prematurity~~ Aortic Valve Atresia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~Sept 1~~ Aug 31, 1967, *to* Sept 1, 1967, *that I last saw the deceased alive on* Aug 31, 1967, *and that death occurred at* 7:30 ~~a.m.~~, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): HAP Myers 384 III M.D.
23b. ADDRESS: 200 E Bannock
23c. DATE SIGNED: 9/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/2/1967
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 9-7-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E-478

Federal Security Agency
United States Public Health Service
Form DH-630 Helen Olson
FIRM NAME: RELYEA MORTUARY-Boise, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: SEP 7 - 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3769
Local Reg. No. 137
Reg. Dist. No. 371

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 011 ADA

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho

LENGTH OF STAY (in this place): 39 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: 240

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding

d. STREET ADDRESS (If rural, give location): 445 Utah St

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Frank	B	GROVE		9	1	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	7 28 90	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Ill.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John H Grove — BIRTHPLACE: Md.

14. MOTHER'S MAIDEN NAME: Mary E Smith — BIRTHPLACE: Md

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1 3

16. SOCIAL SECURITY NO.: 523282754

17. INFORMANT'S OWN SIGNATURE: John B Grove ADDRESS: VA Hospital Records, Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema, pulmonary, obstructive. — INTERVAL BETWEEN ONSET AND DEATH: 12 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Bronchiectasis, rt. lower lobe. — 20 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24, 19 67, *to* 9-1, 19 67, *and that death occurred at* 3:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D. 597 (Degree or title)	VA Center, Boise, Idaho	9-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/12/67	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-13-67	Myrtle Palmer		E-422

FIRM NAME: McBratney-Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3770
Local Reg. No. 136
Reg. Dist. No. 371

RECEIVED SEP 12 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. #2 Christine Lane 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) Rt. #2 Christine Lane

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Luther	D.	Johnson	Sept. 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months	Days	If UNDER 24 HRS.: Hours	Min.
Male	White	Never Married	July 2, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Bois D'Arc, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J.B. Johnson	Boise D'Arc, Mo.	Susan Wallace	Little Rock, Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519-34-9724	Frank Adams by Ryp	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3318

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Vascular Accident and/ Or Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Bronchitis + Emphysema

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April 27, 1966, *to* May 16, 1966, *that I last saw the deceased alive on* May 16, 1966, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bruce Moody	368 MD	Boise	9/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/5/67	Morris Hill Cem.	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-11-67	Myrtle Palmer	Earl Waggoner	E-42

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3771
Local Reg. No. 486
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 6 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1012 O'Farrell St.

3. NAME OF DECEASED (Type or Print)
a. (First) Eufemia
b. (Middle)
c. (Last) Gurule

4. DATE OF DEATH (Month) (Day) (Year) Sept. 3, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Nov. 3, 1909
9. AGE (In years last birthday) 57 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 25
10b. KIND OF BUSINESS OR INDUSTRY Social Security
11. BIRTHPLACE (State or foreign country) Mora County, New Mexico
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Nicolas Gurule — BIRTHPLACE New Mexico
14. MOTHER'S MAIDEN NAME Amada S. Sanchez — BIRTHPLACE New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-30-9887
17. INFORMANT'S OWN SIGNATURE x Sofia Gurulé — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1930

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebellar Glioma — INTERVAL BETWEEN ONSET AND DEATH ca 3 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* _____, 19__, *that I last saw the deceased alive on* Sept 3, 1967, *and that death occurred at* 10:19 pm., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 654 (Degree or title) MD
23b. ADDRESS 425 W. Bannock, Boise
23c. DATE SIGNED 9/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/6/67
24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 9-6-67
REGISTRAR'S SIGNATURE Myrtle Palmer by Helen Olson
25. EMBALMER [signature]
LICENSE NO. E-422

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 6 - 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Amended Sept 15, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3772
Local Reg. No. 492
Reg. Dist. No. 370

BIRTH NO. [redacted]

1. PLACE OF DEATH

a. COUNTY 011 Ada — 307

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise

c. LENGTH OF STAY (in this place) 1 wk

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor — 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho b. COUNTY 011 Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise

d. STREET ADDRESS (If rural, give location) 1607 N. 18th St.

3. NAME OF DECEASED (Type or Print) a. (First) Edward b. (Middle) -- c. (Last) Bell

4. DATE OF DEATH (Month) (Day) (Year) Sept. 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Feb. 9, 1883	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman 24	Manufacturing	Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-56-5437	Norman Bell,	1609 Hays, Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral degeneration — INTERVAL BETWEEN ONSET AND DEATH: 4 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis — 10 yr.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

3347

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1950, 19___, *to* Sept 3, 1967, *that I last saw the deceased alive on* Sept 2, 1967, *and that death occurred at* 1:40 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
H. M. Chaloupka, M.D. 088 (Degree or title) ✓	Boise, Idaho	9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial ✓	Sept 6, 1967	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-7-67	Myrtle Palmer	Dowell D. Demaray	E-509

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Summers Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH 9-11-67

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
SEP 14 1967
Bureau of Vital Statistics

State of Idaho } ss.
County of Ada

Certificate No.

Date Filed Sept. 8. 1967

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Edward Bell (Name on Original Certificate) who died (Was Born or Died) on Sept. 3, 1967 (Date of Event)
in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by immigration papers (Bible Record, Insurance Policy, Etc.) prepared on in 1909 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 8	Feb. 9, 1881	Feb. 9, 1883
Item 9	86	84

Subscribed and sworn to before me this 12th day of September, 19 67

Notary Public, residing at Boise, Idaho

My commission expires Sept 10, 1970

(Seal)

X Signed J. Richard Reed
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

1205 West Bannock Street, Boise Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 12th day of September, 19 67

Notary Public, residing at Boise, Idaho

My commission expires Sept 10, 1970

(Seal)

X Signed Fred E. Parker
(Signature of Any Credible Person)

1205 BANNOCK St. BOISE, IDA.
(Street Address, City, State)

FORM DH 60-155

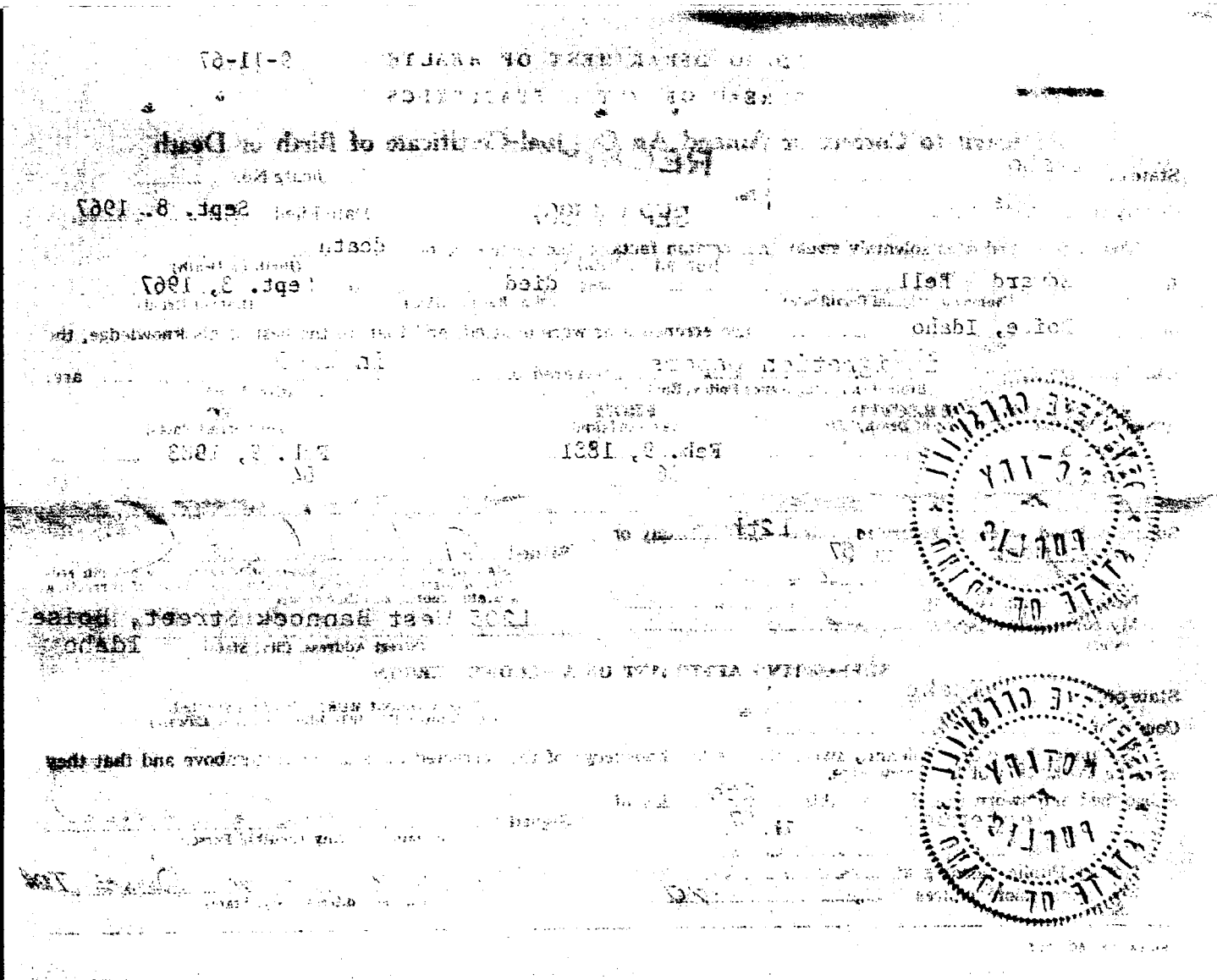

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 492
Reg. Dist. No. 370

RECEIVED SEP 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 1 wk.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1607 N. 18th St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	EDWARD	--	BELL	Sept.	3	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Feb. 9, 1881	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman	Manufacturing	Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519-56-5437	Norman Bell	1609 Hays Boise, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Degeneration — INTERVAL BETWEEN ONSET AND DEATH: 4 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — 10 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1950, *to* Sept 3, 1967 *that I last saw the deceased alive on* Sept 2, 1967 *and that death occurred at* 1:40 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Boise Idaho	9/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 6/67	Morris Hill Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-7-67	Myrtle Palmer	Dowell W. Summers	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 14 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 83

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3773
Local Reg. No. 497
Reg. Dist. No. 370

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 13 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2½ yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived? If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1515 W. Grove St.

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle): W.
c. (Last): CRAFTON

4. DATE OF DEATH (Month) (Day) (Year): Sept. 3 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): unknown 0
8. DATE OF BIRTH: Dec. 25, 1884
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor-retired 06
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (State or foreign country): Owensboro, Kentucky
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Benjamin Crafton — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Martha A. Price — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI 3
16. SOCIAL SECURITY NO.: 427-20-4073
17. INFORMANT'S OWN SIGNATURE: VA - Records — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): CVA — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Atherosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/23/67 *19___, to* 9/3/67 *19___, that I last saw the deceased alive on* 9/1/67 *19___, and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] — 054 (Degree or title): M.D.
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 9/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 8/67
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 9-12-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Fred E. Walker — LICENSE NO. E-483

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 13 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Carl W. Johnston
848 La Cassia

Certificate of Death

STATE OF IDAHO

State File No. 3774
Local Reg. No. 491
Reg. Dist. No. 370

BIRTH NO. 67-82-92 RECEIVED

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada — SEP 7 1967 — 002
b. CITY OR TOWN Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Saint Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 011 Ada
c. CITY OR TOWN Boise
d. STREET ADDRESS (If rural, give location) 7506 Wesley Dr.

3. NAME OF DECEASED (Type or Print): a. (First) TROY b. (Middle) LANE c. (Last) TURNER

4. DATE OF DEATH: (Month) 9 (Day) 3 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Baby

8. DATE OF BIRTH: Sept. 1, 1967

9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 2 — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Ruth Dian Suchanski Turner — BIRTHPLACE: Nampa, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: X Richard B. Haymond — ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7620

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Distress Syndrome — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Premature Birth — 4 Wks.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-1, 19 67, *to* 9-3, 19 67, *that I last saw the deceased alive on* 9-3, 19 67, *and that death occurred at* 1:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD

23b. ADDRESS: 1520 Boise Ave

23c. DATE SIGNED: 9/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/5/67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 9-7-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant — LICENSE NO.: E-478

FIRM NAME: RELYEA MORTUARY-Boise, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63027 Helen Olsen

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 7 - 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3775
Local Reg. No. 558
Reg. Dist. No. 370

RECEIVED
OCT 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. [redacted] Hospital Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 1420 E. 2½ St.

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle):
c. (Last): Pratt

4. DATE OF DEATH (Month) (Day) (Year): Sept. 4, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 4, 1892
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher retired 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oxford, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Pratt — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Olive I. Hunt — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 551-38-4457
17. INFORMANT'S OWN SIGNATURE: Emily R. Pratt — ADDRESS: Meridian

18. CAUSE OF DEATH 332X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Cerebral Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Acute Gastric Ulcer with Recent Hemorrhage — 1 Month

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 20, 1967, *to* Sept 28, 1967, *that I last saw the deceased alive on* Sept 28, 1967, *and that death occurred at* 9:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. L. Quickstad, M.D. 426
23b. ADDRESS: 6613 Ustick Rd, Boise, Idaho
23c. DATE SIGNED: 10/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-7-67
24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 10-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jerread
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3776
Local Reg. No. 757
Reg. Dist. No. 371

BIRTH NO.

RECEIVED SEP 21 1967 Bureau of Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 011 ADA 202

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho

c. LENGTH OF STAY (in this place): 57 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho, 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho. b. COUNTY: 060

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley

d. STREET ADDRESS (If rural, give location): 479 So. Park Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Frank	W	MALCOM.		9	5	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	8-20-19	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Machinist 06	Same	Idaho	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry L Malcom	Virginia	Annettie F. Woodell	Virginia.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE AND ADDRESS
Yes	WW 2 4	519032147	John D. Lewis VA Hospital Records, Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Bleeding esophageal varices	2 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Laennec's Cirrhosis	3 mo. +
DUE TO (c)	Chronic Alcoholism	Unknown
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA		

22. I hereby certify that I attended the deceased from 7-10, 19 67, to 9-5, 19 67, that I last saw the deceased alive on [illegible] and that death occurred at 9:10 PM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis 597 MD. ROBERT C LEWIS, M.D.	VA Center, Boise, Idaho,	9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	9-8-67	Shelley Cemetery	Shelley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-14-67	Myrtle Palmer	Conway Grant	E 478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3777
Local Reg. No. 499
Reg. Dist. No. 370

BIRTH NO.

RECEIVED STATE OF IDAHO

SEP 12 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 Ada 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 Year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor NH 202

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 811 No. 6th. St.

3. NAME OF DECEASED (Type or Print): a. (First) Nell b. (Middle) M. c. (Last) Greenfield

4. DATE OF DEATH: (Month) 9 (Day) 6 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Dec. 2, 1883

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retail Clerk 25

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alexander Porter
BIRTHPLACE: Ireland

14. MOTHER'S MAIDEN NAME: Mary Given
BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-18-5367

17. INFORMANT'S OWN SIGNATURE: X Mabel A Stewart ADDRESS: Durango Colorado

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease — ?

DUE TO (c) Generalized Arteriosclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Old Left Hemiparesis; Post-operative Carcinoma of Colon Oct. 1965 — 1 6 months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/25, 1947, *to* 9/6, 1967, *that I last saw the deceased alive on* 9/5, 1967, *and that death occurred at* 7:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 421

23b. ADDRESS: Boise

23c. DATE SIGNED: 9/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-11-1967

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cem.

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 9-12-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3778
Local Reg. No. 507
Reg. Dist. No. 370

RECEIVED SEP 21 1967

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Bureau
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parma
d. STREET ADDRESS (If rural, give location) Rt. # 2

3. NAME OF DECEASED (Type or Print)
a. (First) Clifford
b. (Middle) (NMI)
c. (Last) Haynes

4. DATE OF DEATH (Month) (Day) (Year) Sept. 6, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH Sept. 10, 1905
9. AGE (In years last birthday) 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper 19
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hull, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wm. Samuel Haynes — BIRTHPLACE Michigan
14. MOTHER'S MAIDEN NAME Mae E. Watson — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) War II 4
16. SOCIAL SECURITY NO. 518-09-2644
17. INFORMANT'S OWN SIGNATURE William E. Haynes — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-6, 1967, *to* 9-6, 1967, *that I last saw the deceased alive on* 9-6, 1967, *and that death occurred at* 10 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE Al H Kingsdall 704 (Degree or title)
23b. ADDRESS 40 Idaho St
23c. DATE SIGNED 9-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Parma Cemetery
24d. LOCATION (City, town, or county) (State) Parma, Idaho

DATE REC'D BY LOCAL REG. 9-14-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Rodney W. Dakan
LICENSE NO. E-508

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Funeral Chapel, Caldwell

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 4 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 28 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3779
Local Reg. No. 495
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH — SEP 12 1967 — Bureau of Vital Statistics
a. COUNTY 011 Ada 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place) 37 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 003 St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 200 Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glenns Ferry,
d. STREET ADDRESS (If rural, give location) Pitchfork Ranch, King Hill

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Ward c. (Last) Knox
4. DATE OF DEATH (Month) (Day) (Year) Sept. 6, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 5, 1908
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Banking 19
10b. KIND OF BUSINESS OR INDUSTRY Idaho State Bank
11. BIRTHPLACE (State or foreign country) Glenns Ferry, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Harry William Knox — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Lula Louise Gertrude Smith — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II
16. SOCIAL SECURITY NO. 518-16-0535
17. INFORMANT'S OWN SIGNATURE — ADDRESS Mrs. W.W. Knox, Glenns Ferry, Idaho

4201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Standstill — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myocardial Infarction — 5 weeks

DUE TO (c) Coronary Thrombosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-1, 1967, *to* 9-6, 1967, *that I last saw the deceased alive on* 9-6, 1967, *and that death occurred at* 4P m., *from the causes and on the date stated above.*

23a. SIGNATURE C C Johnson MD (Degree or title)
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-9-67
24c. NAME OF CEMETERY OR CREMATORY Glenn Rest Cemetery
24d. LOCATION (City, town, or county) Glenns Ferry, Idaho (State)

DATE REC'D BY LOCAL REG. 9-8-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Eldon T. Pearson — LICENSE NO. E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 21 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 3 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 21 1967

Certificate of Death

STATE OF IDAHO

State File No. 3780
Local Reg. No. 506
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada Bureau 207
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 7 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3915 Grover St.

3. NAME OF DECEASED (Type or Print)
a. (First) LILLIE
b. (Middle) ELMINA
c. (Last) COGLE

4. DATE OF DEATH (Month) (Day) (Year) Sept. 6, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH March 16, 1882
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Thayer, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Simpson P. Bennett — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Minerva Risner — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE X Berta A. Denten — ADDRESS 3915 Grover St.

18. CAUSE OF DEATH 334X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) [illegible]
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/24/67, 19__, *to* 9/6/67, 19__, *that I last saw the deceased alive on* 9/3/67, 19__, *and that death occurred at* 7 A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE [illegible] 054 (Degree or title) M.D.
23b. ADDRESS [illegible]
23c. DATE SIGNED 9/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park
24d. LOCATION (City, town, or county) Boise, (State) Idaho

DATE REC'D BY LOCAL REG. 9-14-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER G. W. Waters [signature]
LICENSE NO. E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3781
Local Reg. No. 498
Reg. Dist. No. 390

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada — SEP 12 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL) Boise — c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 010 — b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian Rural
d. STREET ADDRESS (If rural, give location) Rt. 2

3. NAME OF DECEASED (Type or Print): a. (First) James — b. (Middle) Edgar — c. (Last) Wills

4. DATE OF DEATH (Month) (Day) (Year): Sept. 6, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 30, 1882

9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired

10b. KIND OF BUSINESS OR INDUSTRY: 04

11. BIRTHPLACE (State or foreign country): Hill City, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James E. Wills — BIRTHPLACE: Ind.

14. MOTHER'S MAIDEN NAME: Martha Ann Whipple — BIRTHPLACE: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-40-1413

17. INFORMANT'S OWN SIGNATURE: H. C. Hall — ADDRESS: Sonoma, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 157X Adenocarcinoma of the pancreas — INTERVAL BETWEEN ONSET AND DEATH: 4 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with hepatic duct obstruction
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-2 1967 *to* 9-6, 1967, *that I last saw the deceased alive on* 9-6, 1967, *and that death occurred at* 8:50 m., *from the causes and on the date stated above.*

23a. SIGNATURE: J Hugh Cotteleyt MD — 014 (Degree or title)

23b. ADDRESS: 401 Idaho St Boise Ida

23c. DATE SIGNED: 8 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-9-67

24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery

24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 9-12-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Lee Jarred — LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robison Chapel of the Chimes

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 15 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3782
Local Reg. No. 510
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY: 20U Elmore 00U

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 20U

b. COUNTY: Elmore

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry

d. STREET ADDRESS (If rural, give location): Glenns Ferry

3. NAME OF DECEASED (Type or Print): a. (First) GEORGE b. (Middle) RUSSELL c. (Last) MONTAGUE

4. DATE OF DEATH (Month) (Day) (Year): Sept. 7, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 10, 1893

9. AGE (In years last birthday): 73 | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber 21

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Preston, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-09-3355

17. INFORMANT'S OWN SIGNATURE: E. B. Montague — ADDRESS: Glenns Ferry

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Myocardial infarct — 10 years

19a. DATE OF OPERATION: 9/1/67

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of colon, with fistula to jejunum

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/24, 1967, *to* 9/7, 1967, *that I last saw the deceased alive on* 9/7, 1967, *and that death occurred at* 7:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Robert J. Smith MD — (Degree or title)

23b. ADDRESS: 312 W Idaho St., Boise

23c. DATE SIGNED: 9/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/11/67

24c. NAME OF CEMETERY OR CREMATORY: Glenn Rest Cemetery

24d. LOCATION (City, town, or county) (State): Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.: 9-19-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Arthur Smith — LICENSE NO.: E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-8317

BIRTH NO.

RECEIVED
SEP 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3783
Local Reg. No. 514
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY: 011 Ada 415
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 15 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 325 Howe St.

3. NAME OF DECEASED (Type or Print)
a. (First): Larry
b. (Middle): (B)
c. (Last): Alderman

4. DATE OF DEATH (Month) (Day) (Year): Sept. 7, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant 1
8. DATE OF BIRTH: Sept. 7, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours 15 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Raymond D. Alderman
BIRTHPLACE: Washington
14. MOTHER'S MAIDEN NAME: E. Gayle Rice
BIRTHPLACE: Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Raymond D Alderman
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

776X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): prematurity
INTERVAL BETWEEN ONSET AND DEATH: 3/4 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/7, 1967, *to* 9/7, 1967, *that I last saw the deceased alive on* 9/7, 1967, *and that death occurred at* 11:20 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: HAP Myers III 384 (Degree or title) MD 1
23b. ADDRESS: 200 E Bannock
23c. DATE SIGNED: 9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Sept. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Park
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 9-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters G W Waters
LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3784
Local Reg. No. 513
Reg. Dist. No. 370

BIRTH NO. 67-8316

1. PLACE OF DEATH

a. COUNTY: Ada 001 — 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 hr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 325 Howe St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Gary	(A)	Alderman	Sept. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Infant	Sept. 7, 1967				1	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02	None	Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Raymond D. Alderman	Washington	E. Gayle Rice	Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		None	I Raymond D Alderman	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 776X prematurity — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/7, 1967, *to* 9/7, 1967, *that I last saw the deceased alive on* 9/7, 1967, *and that death occurred at* 7 52 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hal Myers 384	MD	200 E Bannock	9/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 11, 1967	Cloverdale Park	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-20-67	Myrtle Palmer	G. W. Waters	E-461

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cloverdale Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3785
Local Reg. No. 524
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN: Meridian
d. STREET ADDRESS (If rural, give location): 135 E. State

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Le Roy	V.	Fisher	Sept. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 6, 1896	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer Retired 04		Melvern, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Fisher	Iowa	Ida Wilson	W. Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-12-7125	Everett Fowler	Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral infarction — INTERVAL BETWEEN ONSET AND DEATH: ±5 d.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Cerebral arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

3332

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/2 1967, *to* 9/7, 1967, *that I last saw the deceased alive on* 9/7, 1967, *and that death occurred at* 10:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Allshouse, M.D. 085 ✓	Boise, Idaho	9/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-12-67	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-26-67	Myrtle Palmer	Geo. Jensen	E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3786
Local Reg. No. 500
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 13 1967

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3503 State St.

3. NAME OF DECEASED (Type or Print): a. (First) Ella; b. (Middle); c. (Last) Gardner

4. DATE OF DEATH (Month) (Day) (Year): Sept. 7, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Jan. 26, 1898

9. AGE (In years last birthday): 69
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Thornburg
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Judith Hainline
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-26-0530

17. INFORMANT'S OWN SIGNATURE: x Jesse F. Lee
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Cerebral Embolus — INTERVAL BETWEEN ONSET AND DEATH: 90 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Rheumatic Heart disease — ?
DUE TO (c): with atrial Fibrillation

II. OTHER SIGNIFICANT CONDITIONS: —
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION: —

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 9/18, 1962, to 9/7, 1967, *that I last saw the deceased alive on* 9/7 1967, *and that death occurred at* 12:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS: Boise

23c. DATE SIGNED: 9/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/11/67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-13-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: A. E. Alden

LICENSE NO.: E 422 E 299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3787
Local Reg. No. 509
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 808 N. Curtis Road Boise Convalescent Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1201 Grand Av.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Thomas	C.	McDonald	Sept.	8	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	March 4, 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04	Farming	Berryville, Arkansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas McDonald	Unkown	Ida Hoffman	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-20-1363	Dorothy E. Mosier	9605 Halstead Boise, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	163X Carcinoma of lung	1 yr.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cerebral metastases	4 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 22 Aug, 1966, *to* 8 Sept, 1967, *that I last saw the deceased alive on* 8 Sept, 1967, *and that death occurred at* 8:25 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles C. Morgan	370 M.D.	Boise, Idaho	11 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 11, 1967	Hazelton Cemetery	Hazelton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-15-67	Myrtle Palmer	Fred E. Walker	E-483

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3788
Local Reg. No. 501
Reg. Dist. No. 370

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

SEP 15 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 7 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 00-3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 370
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grand View
d. STREET ADDRESS (If rural, give location): P.O. Box 165

3. NAME OF DECEASED (Type or Print)
a. (First): Lula
b. (Middle): E.
c. (Last): Erickson

4. DATE OF DEATH (Month) (Day) (Year): Sept. 8, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 30, 1886
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Housewife
11. BIRTHPLACE (State or foreign country): Centertown, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Henry Pace — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Martha Jane Shull — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-24-7348
17. INFORMANT'S OWN SIGNATURE: Mrs Ruth Cote — ADDRESS: 819 Peraltoa Ave. Berkely, Calif.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic Heart Disease — ?
DUE TO (c) Generalized Arteriosclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Paralysis Agitans; Senility — ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/11, 1967, *to* 9/8, 1967, *that I last saw the deceased alive on* 9/8, 1967, *and that death occurred at* 8:25 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 421 MD
23b. ADDRESS: Boise
23c. DATE SIGNED: 9/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-13-67
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Grand View Idaho

DATE REC'D BY LOCAL REG.: 9-15-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Fred E. Walker — LICENSE NO. E-483
FIRM NAME: Summers Funeral HOme

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 26 1967 Bureau of Vital Stat.

Certificate of Death

STATE OF IDAHO

State File No. 3789
Local Reg. No. 520
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 01 b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1319 N. Garden

3. NAME OF DECEASED (Type or Print)
a. (First) Roy b. (Middle) Wils c. (Last) Lewis

4. DATE OF DEATH (Month) (Day) (Year) Sept. 8, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 3, 1889
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Walnut Shade, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William A. Lewis — BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Mary O. Alms — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-44-0054
17. INFORMANT'S OWN SIGNATURE X Mrs Elsie S Lewis — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — propening
DUE TO (c) Diabetes M. — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5, 1967, *to* _____, 19__, *that I last saw the deceased alive on* Sept 8, 1967, *and that death occurred at* 4:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 318 (Degree or title) A.D.
23b. ADDRESS 401 N. Orchard Boise.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Park
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 9-26-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER G. W. Waters [signature]
LICENSE NO. E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3790
Local Reg. No. 515
Reg. Dist. No. 370

RECEIVED SEP 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place) 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 01 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 604 South Phillippi Street

3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) A c. (Last) WHITE

4. DATE OF DEATH (Month) (Day) (Year) Sept. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Jan. 31, 1889	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Operator (Ret)
10b. KIND OF BUSINESS OR INDUSTRY Rooming House
11. BIRTHPLACE (State or foreign country) Bridgeton, Maine
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 528-19-0330
17. INFORMANT'S OWN SIGNATURE X Mrs D. C. Rahn ADDRESS 604 S. Phillippi Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Stroke 334.X — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/2/67, 19__, *to* 9/9/67, 19__, *that I last saw the deceased alive on* 9/9/67, 19__, *and that death occurred at* 5 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 054 (Degree or title) M.D.
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 9/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 9-12-67
24c. NAME OF CEMETERY OR CREMATORY Ogden City Cemetery
24d. LOCATION (City, town, or county) Ogden, Utah (State)

DATE REC'D BY LOCAL REG. 9-20-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-509
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 3791
Local Reg. No. 138
Reg. Dist. No. 371

REGISTRATION Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 18 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho. b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 1827 So. Latah

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) H c. (Last) HOFFMAN

4. DATE OF DEATH: (Month) 9 (Day) 9 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 9-18-09

9. AGE (In years last birthday): 58 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Telegrapher 09

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Woodmere, New York.

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Henry Hoffman — BIRTHPLACE: New York

14. MOTHER'S MAIDEN NAME: Caroline Ernst. — BIRTHPLACE: N.Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 140076042

17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS: VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 490X Acute lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic obstructive pulmonary emphysema
Pulmonary tuberculosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-5, 19 67, to 9-9, 19 67, that I last saw the deceased alive on [illegible] and that death occurred at 6:35 PM, from the causes and on the date stated above.

23a. SIGNATURE Robert C. Lewis M.D. 591 (Degree or title)
ROBERT C LEWIS, M.D.

23b. ADDRESS: VA Center, Boise, Idaho.

23c. DATE SIGNED: 9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/16/67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-15-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER [signature]

LICENSE NO.: E-461

FIRM NAME: Mountain View Funeral Home, Boise

Federal Security Agency
United States Public Health Service

Form DH-63021

Sep 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3792
Local Reg. No. 142
Reg. Dist. No. 371

Certificate of Death

RECEIVED
SEP 27 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 ADA 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE, IDAHO
c. LENGTH OF STAY (in this place): One Day.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA CENTER, BOISE, IDAHO. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BUHL.
d. STREET ADDRESS (If rural, give location): 525 North Broadway.

3. NAME OF DECEASED (Type or Print)
a. (First): DeLawrence
b. (Middle): M
c. (Last): GLINE.

4. DATE OF DEATH (Month) 9 (Day) 11 (Year) 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married. 3
8. DATE OF BIRTH: 9-15-12
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Barber. 21
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Colorado.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Roy B Gline. BIRTHPLACE: Nebr.
14. MOTHER'S MAIDEN NAME: Martha Wolfe. BIRTHPLACE: Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 2 4
16. SOCIAL SECURITY NO.: 519 28 0708
17. INFORMANT'S OWN SIGNATURE: John D. Stark — ADDRESS: VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7220

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute pulmonary edema	1½ hours
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Congestive heart failure	1 week +
DUE TO (c)	Rheumatoid valvular heart disease	unknown
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Rheumatoid arthritis	8 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. [redacted] *attended the deceased from* 9-11, 19 67, *to* 9-11, 19 67, [redacted] *and that death occurred at* 5:50PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert C. Lewis, M.D. — ROBERT C LEWIS, M.D. 597
23b. ADDRESS: VA Center, Boise, Idaho
23c. DATE SIGNED: 9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9-15-67
24c. NAME OF CEMETERY OR CREMATORY: Buhl Cemetery
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 9-21-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, ID.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 23 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 21 1967

Certificate of Death

STATE OF IDAHO

State File No. 3793
Local Reg. No. 508
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1325 Longmont St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1325 Longmont St.

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) Muir c. (Last) Wells

4. DATE OF DEATH (Month) (Day) (Year) Sept. 12, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH May 12, 1884

9. AGE (In years last birthday) 83 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher

10b. KIND OF BUSINESS OR INDUSTRY Public Schools

11. BIRTHPLACE (State or foreign country) Kansas City, Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles E. HucKett — BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Janet Muir — BIRTHPLACE Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-18-3848

17. INFORMANT'S OWN SIGNATURE Merle W. Wells — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial failure — Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Heart Disease — 1½ yrs.
DUE TO (c) Arteriosclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 11/27, 1951, *to* 9/12, 1967, *that I last saw the deceased alive on* 3/13, 1967, *and that death occurred at* early A.M., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 421 (Degree or title)
23b. ADDRESS Boise
23c. DATE SIGNED 9/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/15/67
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cem.
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 9-14-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-422

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alden-Waggoner Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3794
Local Reg. No. 502
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada 302
b. CITY OR TOWN Boise
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 2405 W. Jefferson

3. NAME OF DECEASED (Type or Print) a. (First) Fred b. (Middle) John c. (Last) Dillberg
4. DATE OF DEATH (Month) (Day) (Year) Sept. 12, 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 4, 1883
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Chicago, Ill.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Swan Dillberg BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Dorthy Swanson BIRTHPLACE Sweden
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 335-03-4040
17. INFORMANT'S OWN SIGNATURE & Myrtle E. Dillberg ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Cerebral & Renal Arteriosclerosis
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-11 *1967, to* 9-12 *, 1967, that I last saw the deceased alive on* 9-12 *, 1967, and that death occurred at* 9:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE C C Johnson 261 (Degree or title) MD
23b. ADDRESS Boise Ida
23c. DATE SIGNED 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Park
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 9-20-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER G. W. Waters
LICENSE NO. E-461
FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 7 1982

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3795
Local Reg. No. 147
Reg. Dist. No. 371

BIRTH NO.

RECEIVED SEP 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 011 ADA. 205

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE, IDAHO

c. LENGTH OF STAY (in this place) 147 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE IDAHO. b. COUNTY 011

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise.

d. STREET ADDRESS (If rural, give location) 2501½ State Street.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Homer	G	DAVIS.	9	13	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	6-14-02	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Appliance Repair 21	Same	Illinois	USA.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur Davis	Ill.	Nora Stevens	Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 2 4	325269733	John G Davis	VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, gastro-intestinal exsanguinating — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Carcinoma of the stomach with metastasis — 6 Mos. +

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4-26-67	Carcinoma of stomach, non-resectible	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I attended the deceased from 4-19, 19 67, to 9-13, 19 67, and that death occurred at 8:45AM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. G. CROOKSTON, M.D. 597	V Center, Boise, Idaho	9-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-18-67	Dry Creek Cemetery	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-18-67	Myrtle Palmer	Eldon T. Pearson Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 7 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 9 1974

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3796
Local Reg. No. 504
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 20 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 001 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2½ weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2618 Arthur

3. NAME OF DECEASED (Type or Print): a. (First) Irene b. (Middle) c. (Last) York

4. DATE OF DEATH: (Month) Sept. (Day) 13. (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 27, 1910

9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Adair Co., Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clarence Hulbert — BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Bessie Dwiggins — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-46-8954

17. INFORMANT'S OWN SIGNATURE: Glenn W. York — ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-2-, 1964, *to* 9-13-, 1967, *that I last saw the deceased alive on* 9-13-, 1967, *and that death occurred at* 2:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 343 (Degree or title)

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 16, 1967

24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-20-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: G. W. Waters — LICENSE NO.: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: SEP 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3797
Local Reg. No. 140
Reg. Dist. No. 371

BIRTH NO.

RECEIVED SEP 21 1967

1. PLACE OF DEATH
a. COUNTY 011 Ada 105
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Boise Bureau of Vitality
c. LENGTH OF STAY (in this place) 5 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 235 Boise Valley Sunset Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 231 Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) GRADY c. (Last) QUINN

4. DATE OF DEATH (Month) (Day) (Year) Sept. 13, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH Dec. 13, 1889

9. AGE (In years last birthday) 77 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist 17

10b. KIND OF BUSINESS OR INDUSTRY Boise Payette Lbr.

11. BIRTHPLACE (State or foreign country) Mississippi

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William C. Quinn
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Susan Dotson
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 518-07-3391

17. INFORMANT'S OWN SIGNATURE Gene Quinn ADDRESS Boise, Ida 1124 Broad St

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4301

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1948, *to* Sept 13, 1967 *that I last saw the deceased alive on* Sept 13, 1967, *and that death occurred at* 10:50 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD — **23b. ADDRESS** Boise Idaho — **23c. DATE SIGNED** 9-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** 9-16-67 — **24c. NAME OF CEMETERY OR CREMATORY** Cloverdale Cemetery — **24d. LOCATION** (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 9-19-67 — **REGISTRAR'S SIGNATURE** Myrtle Palmer

25. EMBALMER Lowell W. Summers — **LICENSE NO.** E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3798
Local Reg. No. 522
Reg. Dist. No. 370

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (In this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 25
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Riggins
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle)
c. (Last) MALVICH

4. DATE OF DEATH (Month) (Day) (Year) Sept. 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married 3	October 23, 1915	51		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Logging Contractor 14		Phillips, Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Matthew Malvich	Yugoslavia	Anna Barbara Dedinskey	Czechoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	399-10-2543	Mrs. Florence Malvich	Riggins Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of Liver — INTERVAL BETWEEN ONSET AND DEATH 3 mo (? 3 yrs)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9/1/67	Carcinoma of Liver	YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/1, 1967, *to* 9/13, 1967, *that I last saw the deceased alive on* 9/13, 1967, *and that death occurred at* 1:30P m., 9/13/67, *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
R. A. Forney, M.D. (Degree or title)	425 West Bannock Boise, Idaho	9/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 16, 1967	Riggins Cemetery	Riggins, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-25-67	Myrtle Palmer		E-483

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 25 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3799
Local Reg. No. 512
Reg. Dist. No. 370

RECEIVED SEP 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 513 So. 12th St. (residence)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
d. STREET ADDRESS (If rural, give location): 513 So. 12th St. Boise, Ida.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Alton	R.	Day	9	14	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cau.	No Information	May 31, 1908	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: 21
11. BIRTHPLACE (State or foreign country): Richmond, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edgar Riley Day — BIRTHPLACE: Rexburg, Idaho
14. MOTHER'S MAIDEN NAME: Florence Henderson — BIRTHPLACE: Utah Salt Lake City,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 518 20 3607
17. INFORMANT'S OWN SIGNATURE: x Alice Case Day — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Emphysema — Months.
DUE TO (c) Ill long time, also, Broken Hip — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 E. D. Paris	Coroner	3720 Meadow Drive, Boise.	9-19-67.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	9/19/1967	Joplin Cemetery	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-20-67	Myrtle Palmer	Conway Grant	E478

FIRM NAME: RELYEA MORTUARY, Boise, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 22 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 2 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death 4

STATE OF IDAHO

State File No. 3800
Local Reg. No. 502
Reg. Dist. No. 370

BIRTH NO.

SEP 15 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 10
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1000 Liberty Road

3. NAME OF DECEASED (Type or Print)
a. (First): N ellie
b. (Middle): Jessie Bloom Vail
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): September 14, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced 4
8. DATE OF BIRTH: August 19, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: Elementary School
11. BIRTHPLACE (State or foreign country): Liberal, Kansas
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Henry Bloom — BIRTHPLACE: Baden Baden, Germa y
14. MOTHER'S MAIDEN NAME: Rose Nemnich — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 560 44 1450
17. INFORMANT'S OWN SIGNATURE: Russell A. Relyea — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

463X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 15 Min
Acute Mesenteric Thrombosis — 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Phlebothrombosis of Lower Extremity
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Possible Metastatic Tumor To Liver

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 20, 1967, *to* Sept 13, 1967, *that I last saw the deceased alive on* Sept 13, 1967, *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 426 G. L. Inchold, M. D. 1
23b. ADDRESS: 6613 Ustick Rd, Boise, Idaho
23c. DATE SIGNED: 9/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Sept. 16,67
24c. NAME OF CEMETERY OR CREMATORY: Liberal Kansas Cemetery
24d. LOCATION (City, town, or county) (State): Liberal, Kansas

DATE REC'D BY LOCAL REG.: 9-15-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Relyea Mortua ry

DUTIES:

SEP 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3801
Local Reg. No. 144
Reg. Dist. No. 371

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

OCT 2 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA. 011 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (In this place): 68 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 13 Idaho
b. COUNTY: 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian.
d. STREET ADDRESS (If rural, give location): 1305 Meridian Street.

3. NAME OF DECEASED (Type or Print)
a. (First): Guy
b. (Middle): J
c. (Last): HILTERBRAND

4. DATE OF DEATH (Month) (Day) (Year): 9 15 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 4-15-94
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): MISSOURI
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jeff Hilterbrand. BIRTHPLACE: Mo.
14. MOTHER'S MAIDEN NAME: Belle Watson BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 519076547
17. INFORMANT'S OWN SIGNATURE: John [signature] ADDRESS: VA Hospital Records, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adno Carcinoma of rectal sigmoid with multiple metastasis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ attended the deceased from 7-9, 1967, to 9-15, 1967, ~~[illegible]~~ and that death occurred at 12:35PM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Robert C. Lewis, MD. ROBERT C LEWIS, M.D. 597, 1
23b. ADDRESS: VA Center, Boise, Idaho.
23c. DATE SIGNED: 9-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-18-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 9-25-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jerread
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2. 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3802
Local Reg. No. 505
Reg. Dist. No. 370

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 20 1967
Bureau of Vital Stat.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): years/100
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1407 Euclid Ave. 100

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 01
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1407 Euclid Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): O.
c. (Last): CAPPS

4. DATE OF DEATH (Month) (Day) (Year): Sept. 16, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 11, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor 11
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Clackamas Co. Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred Capps — BIRTHPLACE: Oregon
14. MOTHER'S MAIDEN NAME: Alice Bennett — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-07-8645
17. INFORMANT'S OWN SIGNATURE: X Mrs Frances Capps. — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5271

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Severe Emphysema — Months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 240P *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris 583 (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: 9-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 9-19-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters — LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3803
Local Reg. No. 143
Reg. Dist. No. 371

BIRTH NO.

SEP 27 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Elfreida	J.	Griffith	Sept. 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	Aug. 4, 1889	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm operator 04		Woodsfield, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis B. Griffith	Ohio	Elizabeth Brown	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-60-2184	Lamy Griffith	Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1810

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Transitional Cell Carcinoma of Bladder	6 Mos.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-17-67	Metastases to Pelvis + liver	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 31 May, 1967, *to* 8-26, 1967, *that I last saw the deceased alive on* 8-26-67, 1967, *and that death occurred at* 12:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	395 1403 Idaho St. Boise	18 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-19-67	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-25-67	Myrtle Palmer	[signature]	E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3804
Local Reg. No. 518
Reg. Dist. No. 370

RECEIVED SEP 25 1967 Bureau of V...

BIRTH NO. 014 205

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 5 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 01 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1020 N. 25rd Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Bessie	OLIVE	McBIRNEY	Sept.	16	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Aug. 28, 1871	96				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Marshaltown, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Miner Waters- BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Mary Eckles BIRTHPLACE: Eastholme, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-54-2467
17. INFORMANT'S OWN SIGNATURE: Irene M. Peterson ADDRESS: 1020 N. 23rd Boise

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral encephalomalacia — INTERVAL BETWEEN ONSET AND DEATH: several mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — several yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 21, 1965, to Sept 16, 1967, *that I last saw the deceased alive on* Sept 15, 1967, *and that death occurred at* 8:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul T. Miner 364 (Degree or title): MD
23b. ADDRESS: 105 N. 8th St. Boise, Idaho
23c. DATE SIGNED: 9/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 18/67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 9-25-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Fred C. Summers LICENSE NO.: E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3805
Local Reg. No. 511
Reg. Dist. No. 370

RECEIVED SEP 21 1967

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 014 306
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 016
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 834 Wade Circle

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Paul
c. (Last): Gillmore

4. DATE OF DEATH (Month) (Day) (Year): Sept. 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 17, 1903
9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Real Estate 24
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Nepesta, Colo.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Gillmore
BIRTHPLACE: Colo.
14. MOTHER'S MAIDEN NAME: Daisy Telle
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Samuel Gillmore
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 13, 1967, *to* Sept 18, 1967, *that I last saw the deceased alive on* Sept 18, 1967, *and that death occurred at* 12:15 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 333 1
23b. ADDRESS: 808 La Cassia Dr. Boise Idaho
23c. DATE SIGNED: 9-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-20-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-19-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3806
Local Reg. No. 523
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 9 Monthes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. St Lukes Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 01
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1305 Longmont

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Katherine	Leona	Thiel		9	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	March 3 1896	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 01	Home	Raeville Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Christopher Velder	Nebraska	Sophie Koenig	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		540-44-0700	Catherine L. Skinner	El Sobrante Calif

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Head & Brain Injury — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Street Inter; 13	Boise 011	Ada	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐	NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
9	19	67	820 AM			Crossing street, walking. hit by Auto

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19___, *that I last saw the deceased alive on* ___ 19___, *and that death occurred at* 820 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. Paris 583	Coroner	3720 Meadow Drive, Boise.	9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	9-22-67	St Johns	Ontario	Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. ~~FUNERAL DIRECTOR~~ Embalmer #120	ADDRESS
9-25-67	Myrtle Palmer	John A. Lienkaemper	Nyssa, Or.

Funeral Home: Lienkaemper chapel Nyssa, Or.

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3807
Local Reg. No. 529
Reg. Dist. No. 370

BIRTH NO.

OCT 2 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Ada 01

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (In this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 01

b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 421 Main Street

3. NAME OF DECEASED (Type or Print)

a. (First): Louise

b. (Middle): H

c. (Last): Yongue

4. DATE OF DEATH (Month) (Day) (Year): Sept. 19, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Nov. 8, 1884

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Guide Rock, Nebraska

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Henry Heffner — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Amelia Sidenfadden — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-36-0673A

17. INFORMANT'S OWN SIGNATURE: Edith M. Staten — ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4331

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) clot embolization

DUE TO (c) auricular fibrillation

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-18, 1967, *to* 9-15, 1967 *that I last saw the deceased alive on* 9-15, 1967, *and that death occurred at* 4:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Loren D. Blickenstaff 783 (Degree or title) M.D. 1

23b. ADDRESS: 1015 No 8th St Boise

23c. DATE SIGNED: 22 Sept.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1

24b. DATE: 9/23/67

24c. NAME OF CEMETERY OR CREMATORY: Star Cemetery

24d. LOCATION (City, town, or county) (State): Star, Idaho

DATE REC'D BY LOCAL REG.: 9-27-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: A. E. Alden — LICENSE NO. 299

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3808
Local Reg. No. 516
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH — SEP 22 1967
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3012 Davis Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2321 Idaho St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Mary	Etta	Zankel	Sept. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 5	March 14, 1883	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Waterville, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George A. Storm	Illinois	Mary Ellen Hall	Old Town, Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Michael Zankel	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Myocardial Failure — Interval between onset and death: 3 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary Heart disease — 5 years

DUE TO (c) Arteriosclerosis — 3

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—	—	—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
—	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 8/26, 1967 *to* 9/19, 1967, *that I last saw the deceased alive on* 9/16, 1967, *and that death occurred at* 7:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Boise	9/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/22/67	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-22-67	Myrtle Palmer	G. E. Alden	E-299

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 22 1967 Bureau of Vital

Certificate of Death

STATE OF IDAHO

State File No. 3809
Local Reg. No. 517
Reg. Dist. No. 870

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
c. LENGTH OF STAY (in this place): 100
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 01
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 101 N. Garden

3. NAME OF DECEASED (Type or Print)
a. (First): Frank
b. (Middle): Ernest
c. (Last): Grossmann

4. DATE OF DEATH (Month) (Day) (Year): Sept. 20, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct. 24, 1902
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Illustrator 08
10b. KIND OF BUSINESS OR INDUSTRY: Bur. of Reclam.
11. BIRTHPLACE (State or foreign country): New York City, N.Y.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Herman Grossman — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Matilda Keck — BIRTHPLACE: Volin, Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Frank Ludwig Grossmann — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1533

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Sigmoid Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 13, 1965, *to* Sept 20, 1967, *that I last saw the deceased alive on* Sept 20, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: David Cederlund M.D. 557 (Degree or title)
23b. ADDRESS: Boise Idaho.
23c. DATE SIGNED: 9/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 9/23/67
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Crematory
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-22-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: R. E. Alden — LICENSE NO. E299

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McBratney-Alden-Waggoner Chapel

SEP 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 14 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3810
Local Reg. No. 530
Reg. Dist. No. 370

RECEIVED SEP 29 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 880
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA St. Alphonsus Hospital 008

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 010
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 116 W. Pine St.

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): B.
c. (Last): Kurry

4. DATE OF DEATH (Month) (Day) (Year): Sept. 20, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 15, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert J. Douglas — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Francis Lingenfelter — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-54-1146
17. INFORMANT'S OWN SIGNATURE: James F. Pather — ADDRESS: Boise

18. CAUSE OF DEATH 451X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Ruptured aortic aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis — 2 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic heart disease — 5 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1963, *to* death, 19__, *that I last saw the deceased alive on* Sept 13, 1967, *and that death occurred at* 9:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C R Blackwell MD 046
23b. ADDRESS: 800 La Cassia Way Boise, Ida
23c. DATE SIGNED: 25 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-25-67
24c. NAME OF CEMETERY OR CREMATORY: Star Cemetery
24d. LOCATION (City, town, or county) (State): Star, Idaho

DATE REC'D BY LOCAL REG.: 9-29-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jerread
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 6 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 1 4 1994

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 20 2007

DEC 3 1 2008

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3811
Local Reg. No. 528
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 27 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN: Boise
(If outside corporate limits, write RURAL and give township)
DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 01
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 326 Ada Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Kenneth	E	Wymer	Sept. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Dec. 29, 1905	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Equip. Operator 88	State Hiway Dept.	Emmett, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ellis Claude Wymer	Kansas	Hattie Heidner	Tiskilwa, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-09-4999	Mrs. Kenneth E. Wymer	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Arrhythmia (myocardial)	15 min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cytogenic Myeloid Metaplasia	8 yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/14/67, 19__, *to* 9/21, 1967, *that I last saw the deceased alive on* 9/20, 1967, *and that death occurred at* 12:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 654	M.D.	425 W. Bannock, Boise	9/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/25/67	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-27-67	Myrtle Palmer	C. E. Alden	299

Federal Security Agency
United States Public Health Service
Form DH-6302 Rev.

FIRM NAME: McBratney-Alden-Waggoner Chapel

OCT 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3812
Local Reg. No. 147
Reg. Dist. No. 271

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada. OCT 4 011 1967 202
b. CITY OR TOWN: Boise, Idaho (If outside corporate limits, write RURAL and give township) Bureau of Vital Statistics
c. LENGTH OF STAY IN (this place): 55 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA [illegible], Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 5110 Bloom Lane, Boise, Idaho.
d. STREET ADDRESS (If rural, give location): 5110 Bloom Lane.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Carl	W	GEBAUER	9	21	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	3-24-95	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookeeper & Apartment Owner.	Same	Montana	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John J Gebauer.	Ohio.	Dedarika Kemper.	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW I 3	518 07 5474	John J Gebauer	VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROTIC HEART DISEASE — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9/19/67	Zenkers Diverticulum	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. [illegible] attended the deceased from 7-31, 19 67, to 9-21-, 19 67, that [illegible] and that death occurred at 3:30 P.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
597 R. J. BUNGARD, M.D. R J Bungard	VA Center, Boise, Idaho	9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 25, 1967	Syringa Gardens	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-2-67	Myrtle Palmer	W Dale McMurtrey	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3813
Local Reg. No. 145
Reg. Dist. No. 371

BIRTH NO.

RECEIVED OCT 2 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau of V

c. LENGTH OF STAY (in this place): 66

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 3115 Sycamore Drive

3. NAME OF DECEASED (Type or Print)

a. (First): Ruth

b. (Middle):

c. (Last): Parks

4. DATE OF DEATH: Sept. 21, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 22, 1907

9. AGE (In years last birthday): 59

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ---

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ---

BIRTHPLACE: Kessinger Unknown

14. MOTHER'S MAIDEN NAME: Unknown

BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: A. E. Alden

ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 465X pos. pulm. embolysm — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): atrial fibrillation — 18 mos

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 16 March, 1966, *to* ?, 19___, *that I last saw the deceased alive on* 23 January 1967, *and that death occurred at* 9:45 m., *from the causes and on the date stated above.*

23a. SIGNATURE: Jos. Patten 212

(Degree or title): MD

23b. ADDRESS: 6003 Overland, Boise, Ida.

23c. DATE SIGNED: 28 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/27/67

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-2-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: A. E. Alden

LICENSE NO.: 299

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3814
Local Reg. No. 160
Reg. Dist. No. 371

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

OCT 20 1967 710

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): KUNA
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): INDIAN CREEK 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 1-42
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 515 Washington

3. NAME OF DECEASED (Type or Print)
a. (First): FRANK
b. (Middle): LAWRENCE
c. (Last): WARRICK III

4. DATE OF DEATH (Month) (Day) (Year): Sept. 21 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married /
8. DATE OF BIRTH: April 1, 1966
9. AGE (In years last birthday): 1 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none ~~00~~ 02
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Palm Springs, California
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Frank Lawrnce Warrick II — BIRTHPLACE: Newark, N.J.
14. MOTHER'S MAIDEN NAME: Amy Joanne Randolph — BIRTHPLACE: Minneapolis, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: + Frank L Warrick JR — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by Drowning. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c) Body not recovered for 25 days.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* While playing, fell into Indian Creek, near where he was staying

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 000
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* P *m., from the causes and on the date stated above.*

23a. SIGNATURE: D Paris 583 (Degree or title): Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Terry K. Lawson — LICENSE NO. E522
FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3815
Local Reg. No. 525
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
SEP 28 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 413 S. 4th. Street

3. NAME OF DECEASED (Type or Print)
a. (First): Susan
b. (Middle): Delia
c. (Last): Cantral

4. DATE OF DEATH (Month) (Day) (Year): Sept. 21, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 5, 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Eureka Springs, Arkansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fulton — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-05-4791
17. INFORMANT'S OWN SIGNATURE: James M. Cantral — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/22, 1967, *to* 9/21, 1967, *that I last saw the deceased alive on* 9/21, 1967 *and that death occurred at* 11:15 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 654 [signature] M.D.
23b. ADDRESS: 425 W Bannock, Boise
23c. DATE SIGNED: 9/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/26/67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-27-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. E. Alden — LICENSE NO. 299

Federal Security Agency
United States Public Health Service
Form DH-[illegible] Alden Obsm
FIRM NAME: McBratney-Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3816
Local Reg. No. 526
Reg. Dist. No. 370

RECEIVED
SEP 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2323 E. Boise Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Dora b. (Middle) Hull c. (Last) Rogers

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 21, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Nov. 11, 1886

9. AGE (In years last birthday): 80
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Manlove Hull
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Lois Daniel
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-07-4538A

17. INFORMANT'S OWN SIGNATURE: Frank L. Thompson
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral thrombosis 3327
INTERVAL BETWEEN ONSET AND DEATH: 3 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1, 19 67, *to* Sept 21, 19 67, *that I last saw the deceased alive on* Sept 21, 19 67 *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 054 (Degree or title): M.D.
23b. ADDRESS: [illegible]
23c. DATE SIGNED: 9/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/23/67
24c. NAME OF CEMETERY OR CREMATORY: Joplin Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-28-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. E. Alden
LICENSE NO.: 299
FIRM NAME: McBratney-Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

SEP 25 1967

STATE OF IDAHO

State File No. 3817
Local Reg. No. 519
Reg. Dist. No. 370

BIRTH NO.

Bureau of Vital Statistics 307

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 7 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 812 North 32nd Street

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) M. c. (Last) MARLATT

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 21, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married

8. DATE OF BIRTH: Dec. 21, 1897

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Marlatt
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Lucy E. Daly
BIRTHPLACE: Unionville, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-05-4952

17. INFORMANT'S OWN SIGNATURE: William E Marlatt
ADDRESS: 616 Borah St. Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute perforated appendicitis — INTERVAL BETWEEN ONSET AND DEATH: wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-14-67

19b. MAJOR FINDINGS OF OPERATION: perforated appendix

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-14, 1967, *to* 9-21, 1967, *that I last saw the deceased alive on* 9-21, 1967, *and that death occurred at* 3:12 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. B. Patterson M.D.

23b. ADDRESS: Boise, Ida

23c. DATE SIGNED: 9-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-25-67

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 9-25-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: W. Dale McCluskey

LICENSE NO.: E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 3818
Local Reg. No. 148
Reg. Dist. No. 371

BIRTH NO. RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 014 OCT 4 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Bureau of Vital
c. LENGTH OF STAY (in this place): In Office 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4900 Alworth

3. NAME OF DECEASED (Type or Print)
a. (First): DOROTHY
b. (Middle): MARIE
c. (Last): LANE

4. DATE OF DEATH (Month) 9 (Day) 23 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 10/3/1918
9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Omaha, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Fenton — BIRTHPLACE: Lineville, Iowa
14. MOTHER'S MAIDEN NAME: Johana Margaret Ackerman — BIRTHPLACE: Beatrice, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-34-7596
17. INFORMANT'S OWN SIGNATURE: X Lee Lane — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushed skull & Chest. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None determined. Speed not envolved. Alcohol Not envolved.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 1 Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 3 Hiway 2I 010 Ada Idaho
21d. TIME OF INJURY (Month) 9 (Day) 23 (Year) 67 (Hour) III5P m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Pickup Truck rollover. down embankment, 200 yards.

22. *I hereby certify that I attended the deceased from* Did Not, 19 See, *to* Alive, 19___, *that I last saw the deceased alive on* ____, 19___, *and that death occurred at* III5P *m., from the causes and on the date stated above.*

23a. SIGNATURE: E D Paris 583 (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: 9-27-67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/26/67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 10-2-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant — Conway Grant
LICENSE NO.: 478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Relyea Mortuary

OCT 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 23 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3819
Local Reg. No. 527
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada SEP 27 1967 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. St. Lukes Hosp. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 10 Florida
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Indian Harbor Beach
d. STREET ADDRESS (If rural, give location): 1031 Park Drive

3. NAME OF DECEASED (Type or Print)
a. (First): Harold
b. (Middle): John
c. (Last): Barritt

4. DATE OF DEATH (Month) (Day) (Year): Sept. 24, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 20, 1922
9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY: Cross Country
11. BIRTHPLACE (State or foreign country): North Carolino
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Barritt — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unk — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW 2 — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 075 16 8575
17. INFORMANT'S OWN SIGNATURE: A. E. Alden — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): ---
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): ---
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): ----

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* as Coroner only, 19__, *that I last saw the deceased alive on* ------, 19__, *and that death occurred at* 11:15 am, *from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris 483 (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise
23c. DATE SIGNED: 9/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/28/67
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county) (State): Orlando, Florida

DATE REC'D BY LOCAL REG.: 9-27-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. E. Alden — LICENSE NO. 299

Federal Security Agency
United States Public Health Service
Form DH-63021 Helen Olson FIRM NAME: McBratney-Alden-Waggoner

DUTIES:

SEP 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3821
Local Reg. No. 521
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
SEP 26 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada (01)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 300 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus (003)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho (01)
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1116 O'Farrell

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Frank	William	Shelton	Sept. 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	Nov. 5, 1902	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Printing Pressman	Statesman	Dallas, Oregon	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew M. Shelton	Va.	Mary E. Killian	Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	6----------		Mrs F.W. Shelton	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1993

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Met. disease to the T-8 vertebrae body	YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept 18 *19*67, *to* Sept 24, *19*67, *that I last saw the deceased alive on* _____, *19*___ *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Al H Kuykendall MD	401 Idaho St	9-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-27-67	Cloverdale Cemetery	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER Eldon T. Pearson	LICENSE NO.
9-26-67	Myrtle Palmer	Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Gibson Funeral Home

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 19 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

3rd

Certificate of Death

STATE OF IDAHO

State File No. 3822
Local Reg. No. 535
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 6 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2314 Kootenai 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2314 Kootenai

3. NAME OF DECEASED (Type or Print)
a. (First): Mike
b. (Middle): --------
c. (Last): Rukavina

4. DATE OF DEATH (Month) (Day) (Year): Sept. 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single /
8. DATE OF BIRTH: May 10, 1888
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: M. K. Co.
11. BIRTHPLACE (State or foreign country): Perusich, Yugoslavia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Stepan Rukavina — BIRTHPLACE: Yugoslavia
14. MOTHER'S MAIDEN NAME: Matija Nehimouich — BIRTHPLACE: Yugoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs Charles Stover — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4330

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease, with heart block. (Adams-Stokes syndrome) — INTERVAL BETWEEN ONSET AND DEATH: Few years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Pulmonary emphysema — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I* didn't *attended the deceased from* _____, 19__, *to* _____, 19__, *that I* never *saw the deceased alive on* _____, 19__, *and that death occurred at* 6.15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. L. Newcombe 387 M.D.
23b. ADDRESS: 512 N. 16th Street, Boise, Idaho, 83702
23c. DATE SIGNED: 10.2.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-28-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise, Idaho Ada

DATE REC'D BY LOCAL REG.: 10-3-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 15 1968

JAN 22 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Attack 401 N. Orchard

Certificate of Death

STATE OF IDAHO

State File No. 3823
Local Reg. No. 534
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 4 1967

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN: Boise
Bureau of Vital (township)
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Rt. #1, Utahna Road

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	LETTIE	VEVA	MAXEY		9	25	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed.	January 24, 1894	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Polk County, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Milton Henson — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME: Louise Hill — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Mrs Eva Smith — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1992 Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1-2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: Diabetes M.
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-10, 19 59, *to* 9-25, 1967, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 318 (Degree or title) MD
23b. ADDRESS:
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-28-67
24c. NAME OF CEMETERY OR CREMATORY: Joplin Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-2-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant [signature] LICENSE NO.: E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3824
Local Reg. No. 151
Reg. Dist. No. 371

BIRTH NO.

RECEIVED OCT 6 1967 Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE, IDAHO
c. LENGTH OF STAY (in this place): 18 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa. 142
d. STREET ADDRESS (If rural, give location): 229 Smith Street.

3. NAME OF DECEASED (Type or Print): a. (First) Garfield b. (Middle) S c. (Last) CURRY.

4. DATE OF DEATH: (Month) 9 (Day) 26 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 9-27-98

9. AGE (In years last birthday): 68
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Construction Work.

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): England.

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: George H Curry.
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Elizabeth Winters.
BIRTHPLACE: Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 707 14 9152

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: John D. Curry
VA HOSPITAL RECORDS, BOISE, IDAHO.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adeno-carcinoma of the stomach with metastases — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Intestinal obstruction due to carcinoma of stomach — ?
DUE TO (c) Rupture of jejunum — 24-26 hrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-25-67

19b. MAJOR FINDINGS OF OPERATION: See diagnoses under #18.

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. [redacted] attended the deceased from 9-8, 19 67, to 9-26, 19 67, [redacted] and that death occurred at 7:25AM m., from the causes and on the date stated above.

23a. SIGNATURE: W. G. CROOKSTON, M.D. 597 (Degree or title)

23b. ADDRESS: VA CENTER, BOISE, IDAHO.

23c. DATE SIGNED: 9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/30/67

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: 10-5-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Larry J. Krouse

LICENSE NO.: E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3825
Local Reg. No. 149
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA — OCT 4 1967 — Bureau of Vital Statistics — 011 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE, IDAHO.
c. LENGTH OF STAY (in this place): 523 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 604

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 440
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 718 E. Court Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	John	R	MARSHALL		9	26	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	4-5-88	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Millman 08	Same	Utah	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward T Marshall	Virgina	Eliza Griffiths	Wgland.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1 3	712 09 3207	[signature]	VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION — 5271

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor Pulmonale. — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Emphysema, chronic, obstructive. — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
VA m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. [redacted] attended the deceased from 3-21, 19 66, to 9-26, 19 67, [redacted] and that death occurred at 7:55PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D. 597	VA CENTER, Boise, Idaho.	9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal	Sept. 26'67		Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-2-67	Myrtle Palmer	A. Dale McMurtrey	E-410

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 4 - 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 6 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 208.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3826
Local Reg. No. 536
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 6 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural----Boise
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Charles b. (Middle) Ray c. (Last) Reineke

4. DATE OF DEATH (Month) (Day) (Year): Sept. 27, 1967.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 27, 1907

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurseryman 08

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Forrest Serv.

11. BIRTHPLACE (State or foreign country): Sheridan, Wyoming.

12. CITIZEN OF WHAT COUNTRY?: N

13. FATHER'S NAME: Henry Reineke
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Emma Nunamaker
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-46-1658

17. INFORMANT'S OWN SIGNATURE: Mrs C.R. Reineke
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 7 Days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-21-67, 19__, *to* 9-27, 1967, *that I last saw the deceased alive on* 9-27, 1967, *and that death occurred at* 9 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: D.B. Patterson (Degree or title) MD
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: 10-5-67
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Jay D. Krouse
LICENSE NO.: E-447

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

OCT 9 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 13 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 1827
Local Reg. No. 450
Reg. Dist. No. 471

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY: Ada — OCT 4 1967 — 011 301

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho

c. LENGTH OF STAY (in this place): One Day

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho. b. COUNTY: 010

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle

d. STREET ADDRESS (If rural, give location): Box 147

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Silas	W	HURLBERT		9	27	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	9-1-95	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Forrest Service Work.

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Mo.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John W Hurlbert. BIRTHPLACE: Mo.

14. MOTHER'S MAIDEN NAME: Lilly Hendricks BIRTHPLACE: Ill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1

16. SOCIAL SECURITY NO.: 519 16 1900

17. INFORMANT'S OWN SIGNATURE: John W Hurlbert ADDRESS: VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage, gastrointestinal — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Tumor of head of pancreas — 18 months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

I hereby certify that I attended the deceased from 9-26, 1967, to 9-27, 1967, that I last saw the deceased alive on [illegible], and that death occurred at 4 PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. J. BUNGARD, M.D.	VA Center, Boise, Idaho	9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-2-67	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-4-67	Myrtle Palmer	Wade McMurtrey	E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign his name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 4 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3828
Local Reg. No. 532
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 3 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 9 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 01
b. COUNTY: Ada 309
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6910 Copper Drive

3. NAME OF DECEASED (Type or Print): a. (First) Rose b. (Middle) Alice c. (Last) Stivers

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 27, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 13, 1888
9. AGE (In years last birthday): 79 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank Barber — BIRTHPLACE: France
14. MOTHER'S MAIDEN NAME: McLaughlin — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-54-9539
17. INFORMANT'S OWN SIGNATURE: Harry R Stivers — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CEREBRAL THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 WKS.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 2, 19 F, *to* Sept. 27, 1967, *that I last saw the deceased alive on* Sept 27, 1967, *and that death occurred at* 9:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: C C Gibson 261 — (Degree or title): MD — 23b. ADDRESS: Boise Idaho — 23c. DATE SIGNED: 9-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 9-29-67 — 24c. NAME OF CEMETERY OR CREMATORY: Morris Hill — 24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 10-3-67 — REGISTRAR'S SIGNATURE: Myrtle Palmer — 25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 3 - 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3829
Local Reg. No. 547
Reg. Dist. No. 370

RECEIVED
OCT 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 201
c. LENGTH OF STAY (in this place): 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 010
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
d. STREET ADDRESS (If rural, give location): Rt. 3

3. NAME OF DECEASED (Type or Print): a. (First) Jessie b. (Middle) S. c. (Last) Calnon

4. DATE OF DEATH (Month) (Day) (Year): Sept. 28, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 29, 1883
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Decatur, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Albert White — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Mary Baird — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-24-9198
17. INFORMANT'S OWN SIGNATURE: Mark B. Calnon — ADDRESS: Meridian

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): C.V.A. — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 19 52 *to* Sept. 19 67, *that I last saw the deceased alive on* Sept 19 67, *and that death occurred at* 4:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: D. M. Thomas 528 (Degree or title)
23b. ADDRESS: 305 Fort St Boise
23c. DATE SIGNED: 10/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-2-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 10-11-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Sep Jarred
LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 1 7 1993

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3830
Local Reg. No. 157
Reg. Dist. No. 371

RECEIVED OCT 20 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (in this place): 42 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho.
b. COUNTY: 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 1815 State Street.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	William	V	TURNER		9	29	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	10-7-96	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Realtor. 24	Same	Idaho.	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William S Turner	Idaho	Mary Turmes	So. Dak.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1 3	518 10 3794	John D. Turner	VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia, hypostatic	24 hrs.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Cachexia	3 mo.
DUE TO (c)	Uremia	3 days
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Arteriosclerosis, generalized	several yrs.
	Carcinomata of bladder & right kidney	5 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-27-67	Left ureteral calculi	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
VA m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

I attended the deceased from 8-18, 19 67, to 9-29-67, 19 67, and that death occurred at 2:45 AM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. K. HELFERTY, M.D.	VA Center, Boise, Idaho.	9-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/2/67	Bruneau Cemetery	Bruneau, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-19-67	Myrtle Palmer	H. Vel Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT-20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3831
Local Reg. No. 551
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada OCT 12 1967 011 303
b. CITY OR TOWN Boise (If outside corporate limits, write RURAL and give township) Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 30 47
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Alphonsus Hosp. 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42 b. COUNTY Twin Falls
c. CITY OR TOWN Twin Falls (If outside corporate limits, write RURAL and give township) 83301
d. STREET ADDRESS 1937 Falls Ave East (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Helen b. (Middle) P. c. (Last) Reese
4. DATE OF DEATH (Month) (Day) (Year) September 30, 1967
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 5
8. DATE OF BIRTH Nov. 22, 1913
9. AGE (In years last birthday) 53 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME Ewing Wilson BIRTHPLACE Kentucky
14. MOTHER'S MAIDEN NAME Nina Mitchell BIRTHPLACE Minnesota
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 54 0337
17. INFORMANT'S OWN SIGNATURE Robert M Reese ADDRESS Twin Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES X NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-26 1967, *to* 9-30, 1967, *that I last saw the deceased alive on* 9-30, 1967, *and that death occurred at* 4:15P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED 10/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/3/67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10-12-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER
LICENSE NO. 343

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

OCT 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 30 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 12 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3832
Local Reg. No. 542
Reg. Dist. No. 370

Certificate of Death

RECEIVED
OCT 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 316
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (in this place): 16das.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder, Idaho
d. STREET ADDRESS (If rural, give location): Box 512

3. NAME OF DECEASED (Type or Print)
a. (First): LOUIS
b. (Middle): L
c. (Last): KRALL

4. DATE OF DEATH (Month) (Day) (Year): 9 30 67

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 26, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Land Developer 11
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Meridian, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis Krall — BIRTHPLACE: Meridian, Idaho
14. MOTHER'S MAIDEN NAME: Julia A Allen — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): One 3
16. SOCIAL SECURITY NO.: 518-16-7019
17. INFORMANT'S OWN SIGNATURE: Mrs. Eva M. Krall — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro-vascular infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Total laryngectomy, right radical neck dissection.

19a. DATE OF OPERATION: Sept 13, 1967
19b. MAJOR FINDINGS OF OPERATION: Carcinoma right vocal cord. Post-irradiation
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 13, 1966, *to* Sept 30, 1967, *that I last saw the deceased alive on* Sept 29, 1967, *and that death occurred at* 4:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 265 M.D. 1
23b. ADDRESS: 425 W. Bannock St. Boise
23c. DATE SIGNED: Oct 3, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10/4/67
24c. NAME OF CEMETERY OR CREMATORY: Wilder
24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: 10-9-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Lucy M. Flahiff — LICENSE NO.: E393
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 17 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 26 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3833
Local Reg. No. 537
Reg. Dist. No. 270

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada OCT 5 1967
b. CITY OR TOWN Boise (If outside corporate limits, write RURAL and give township) Bureau of Vital Statistics
LENGTH OF STAY (in this place) years

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1605 North 23rd

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1605 North Twenty-third

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	TYRUS	COBB	HURTT	September 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	June 11, 1913	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
salesman	insurance	Caldwell, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Roy T. Hurtt	Lincoln, Nebraska	Pearl Hustead	Hillsboro, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	----	519-20-2363	Gwladys M Hurtt	1605 N. 23rd Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1227 Carcinoma of Prostate — INTERVAL BETWEEN ONSET AND DEATH: 5+ yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-12-63	Carcinoma of prostate	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept, 1963, *to* death, 19__, *that I last saw the deceased alive on* Aug 20, 1967, *and that death occurred at* 3:00a m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
T B Jeppesen DO	MD	Boise Idaho	10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 3, 1967	Morris Hill Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-5-67	Myrtle Palmer	J. Willard Reed	E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 5 - 1961

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3834
Local Reg. No. 538
Reg. Dist. No. 370

RECEIVED
OCT 5 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 108 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 200 Sunrise Rim

3. NAME OF DECEASED (Type or Print)
a. (First): EDNA
b. (Middle): MAY 292
c. (Last): WILSON

4. DATE OF DEATH (Month) (Day) (Year): Sept. 30, 1967

5. SEX: Female
6. COLOR OR RACE: White 09
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 29, 1893
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone operator
10b. KIND OF BUSINESS OR INDUSTRY: telephone co.
11. BIRTHPLACE (State or foreign country): Etna, California
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James William Facey — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Martha Allen — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 558-09-3432
17. INFORMANT'S OWN SIGNATURE: X Richard E Stickel — ADDRESS: Baltimore, Maryland

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Generalized arteriosclerosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Rheumatoid arthritis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/6, 1961, *to* 9/30, 1967, *that I last saw the deceased alive on* 8/25, 1967, *and that death occurred at* 5:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. A. Cloheny, M.D. 095
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 10/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 10-2-67
24c. NAME OF CEMETERY OR CREMATORY: Etna Cemetery
24d. LOCATION (City, town, or county) (State): Etna, California

DATE REC'D BY LOCAL REG.: 10-5-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-509
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 5 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3835
Local Reg. No. 531
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Ada 011	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho 011 b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise c. LENGTH OF STAY (in this place): 000	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 817 Hays St.

3. NAME OF DECEASED (Type or Print)	a. (First): John	b. (Middle):	c. (Last): Molenaar	4. DATE OF DEATH (Month) (Day) (Year): Sept. 30, 1967
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2	8. DATE OF BIRTH: Oct. 22, 1882	9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming 04	10b. KIND OF BUSINESS OR INDUSTRY: Same	11. BIRTHPLACE (State or foreign country): Bever Wijk, Netherlands	12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Unknown	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Jake N Molenaar	ADDRESS	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4331

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Emboli & infarction — INTERVAL BETWEEN ONSET AND DEATH: Wks.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Auricular Fibrillation — Mos.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* hepatic congestion

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☒ NO ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-27, 1967, *to* 9-30, 1967, *that I last saw the deceased alive on* 9-30, 1967, *and that death occurred at* 9:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: D. B. Patterson #12 (Degree or title)	23b. ADDRESS: Boise	23c. DATE SIGNED: 10-2-67
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 10/4/67	24c. NAME OF CEMETERY OR CREMATORY: St. John's
24d. LOCATION (City, town, or county) (State): Ontario, Oregon		
DATE REC'D BY LOCAL REG.: 10-2-67	REGISTRAR'S SIGNATURE: Myrtle Palmer	25. EMBALMER: Glen G. Siren — LICENSE NO. 498

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME McBratney-Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3836
Local Reg. No. 146
Reg. Dist. No. 37

BIRTH NO.

RECEIVED

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 010 OCT 3 1967 400
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lucky Peak Bureau of V[illegible] area
c. LENGTH OF STAY (in this place): hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA St. Lukes Hosp. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 435 East 10th North

3. NAME OF DECEASED (Type or Print): a. (First) Nelson b. (Middle) Orris c. (Last) Griffith

4. DATE OF DEATH (Month) (Day) (Year): Sept. 30, 1967

5. SEX: male

6. COLOR OR RACE: white 19

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Jan. 3, 1913

9. AGE (In years last birthday): 54
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk and accountant

10b. KIND OF BUSINESS OR INDUSTRY: Bank and Construction

11. BIRTHPLACE (State or foreign country): Soldier, Blaine Cty, Idaho

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: James Nelson Griffith
BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Verna M. Couch
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 07 5558

17. INFORMANT'S OWN SIGNATURE: K Rita L Griffith
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4207

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis.
INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Was hunting in Hills, with Companions, when he suddenly Collapsed. — 30 Mins

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See *to* Alive, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 315P *m., from the causes and on the date stated above.*

23a. SIGNATURE: D. Paris 583 (Degree or title) Coroner

23b. ADDRESS: 3720 Meadow Drive, Boise

23c. DATE SIGNED: 10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: October 4, 1967

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-3-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant

LICENSE NO.: E 478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 3 - 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3837
Local Reg. No. 548
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 13 1967 Bureau of Vital Statistics

011 2-01 337

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 24 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Boise Convelescent Center 334

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 010 b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ##### Meridian,
d. STREET ADDRESS (If rural, give location): 1316 W. 1st

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Hilma	J.	Aho	Sept. 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	June 24, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Finland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Simon Simlin	Finland	Unk	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.: 518-03-0588
17. INFORMANT'S OWN SIGNATURE: Mrs. George Sunnemaker ADDRESS: Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): thrombophlebitis — months
DUE TO (c): ASHD & cor pulmo — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Peptic disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1966, 19__, *to* 1967, 19__, *that I last saw the deceased alive on* 28 Sept, 1967, *and that death occurred at* 6:45P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lee D. Pulley MD	925 E 1st Meridian Id	4 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-4-67	Meridian Cemetery	Meridian, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-11-67	Myrtle Palmer	Geo Jerred	E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3838
Local Reg. No. 16
Reg. Dist. No. 300

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Council Community Hospital 017

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 440
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ESTHER
b. (Middle): ELLEN
c. (Last): THOMASON

4. DATE OF DEATH (Month) 9 (Day) 4 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed
8. DATE OF BIRTH: 3/21/1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): La Conner, Washington
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: David Hustead — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Lucy Stephenson — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: R. Dave Thomason — ADDRESS: Weiser, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — 5 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-9- *, 19*67*, to* 9-4- *, 19*67*, that I last saw the deceased alive on* 9-4 *, 19*67*, and that death occurred at* 1:10p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 154 1
23b. ADDRESS: Council, Idaho
23c. DATE SIGNED: 9/4/1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/7/1967
24c. NAME OF CEMETERY OR CREMATORY: Indian Valley Cemetery
24d. LOCATION (City, town, or county) (State): Indian Valley, Idaho

DATE REC'D BY LOCAL REG.: 9-12-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E-464

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

...of De...
...IDAHO

...ock ... 1967

2. USUAL RESIDENCE
a. STATE Idaho ... Bannock

...corporate limits, ... RURAL and ... town ... Pocatello

c. CITY OR TOWN (If ... corporate limits, ... RURAL and ... town) Pocatello

... OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hosp. 018

d. STREET ADDRESS (If rural, ...) 605 No. 6th Av.

3. NAME OF DECEASED (Type or Print) a. (First) HORATIO b. (Middle) NELSON c. (Last) MOORE

4. DATE OF DEATH (Month) (Day) (Year) Aug. 27 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Oct. 12, 1884

9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 08

10b. KIND OF BUSINESS OR INDUSTRY City

11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter J. Moore BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Margaret Frew BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-05-8937

17. INFORMANT'S OWN SIGNATURE Ruby Moore Pocatello Idaho ADDRESS

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary artery occlusion — INTERVAL BETWEEN ONSET AND DEATH 2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardiovascular disease — 20 yr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1967 *to* Aug 27, 1967 *that I last saw the deceased alive on* Aug 26, 1967 *and that death occurred at* 1:00 p *m., from the causes and on the da... above.*

23a. SIGNATURE (Degree or title) R.J. Emerson M.D. 158

23b. ADDRESS Pocatello, Idah... ...NED ...67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Aug. 30, 1967

24c. NAME OF CEMETERY OR CREMATORY Mountainview

24d. LOCATION (City, ...te) Pocatello ...ho

DATE REC'D BY LOCAL REG. OCT 1967

REGISTRAR'S SIGNATURE ...

25. EMBALMER George W. Kar...

FIRM NAME: Downard Funeral H...

Federal Security Agency
United States Public Health Service

Form ...-69021

...must sign with BLACK INK in OWN handwriting. ... after a careful investigation. Use BLACK ink ... correspondence to BUREAU OF VITAL ST... ...IDAHO
...FICA 38-206 and ...

APR 21 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3849
Local Reg. No. 239
Reg. Dist. No. 511

BIRTH NO.

SEP 11 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock (093)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 3 days (313)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital (019)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho (06)
b. COUNTY: Bingham (007)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 95 North Fisher St.

3. NAME OF DECEASED (Type or Print): a. (First) LYLE; b. (Middle) ELAINE; c. (Last) GIBSON

4. DATE OF DEATH (Month) (Day) (Year): September 1, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married (3)

8. DATE OF BIRTH: October 19, 1924

9. AGE (In years last birthday): 42
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife (01)

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clyde E. Worthen Sr.
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Lula McCleery
BIRTHPLACE: Murray, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-26-3356

17. INFORMANT'S OWN SIGNATURE: Norma L Gibson
ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION (3437)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Encephalitis
INTERVAL BETWEEN ONSET AND DEATH: 2-3 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug 30, 1967, *to* September 1, 1967, *that I last saw the deceased alive on* September 1, 1967, *and that death occurred at* 4:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (077)
(Degree or title): M.D. (1)
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Sept 4, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Groveland cemetery
24d. LOCATION (City, town, or county) (State): Bingham county Idaho

DATE REC'D BY LOCAL REG.: SEP 7 1967
REGISTRAR'S SIGNATURE: Gloria Coates
25. EMBALMER: C. Dean Hill
LICENSE NO.: E-466
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Winter

Certificate of Death

STATE OF IDAHO

State File No. 3841
Local Reg. No. 245
Reg. Dist. No. 510

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN: Pocatello
LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): South Grant Extension

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOE	(FRESCHLIE)	FORD	Sept. 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	Feb. 21, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cabinet Maker 21	Woodwork shop	Hungary	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mike Freschlie	Hungary	Unknown	Hungary

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Mary Ann Burrows	Pocatello, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Hemorrhage	12 hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hyp. Cerebral Arteriosclerosis	3 days
DUE TO (c)	Senile Debility	10 yrs
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	87 years of age	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	201 East	9/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-6-67	Mountainview Cem.	Pocatello, Idaho

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 11 1967	Gloria Dopita	John P. Thomas	E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3842
Local Reg. No. 254
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 226 South Johnson

3. NAME OF DECEASED (Type or Print)
a. (First): JOSEPH
b. (Middle): HENRY 018
c. (Last): KNOWLES

4. DATE OF DEATH (Month) (Day) (Year): Sept. 2, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 3, 1879
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Railroad and Grocer 10
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Logan, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph C. Knowles — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Laura Baugh — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs J. H. Knowles — ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary arteriosclerosis
DUE TO (c): Diabetes Mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Extensive Nephrosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Calvin Buhler 069 MD
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: SEP 25 1967
REGISTRAR'S SIGNATURE: Glorea Dopita
25. EMBALMER: F. B. [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 3 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where ~~death occurred~~ for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Howard

Certificate of Death

STATE OF IDAHO

State File No. 3843
Local Reg. No. 240
Reg. Dist. No. 5-20

RECEIVED SEP 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN: Pocatello
c. LENGTH OF STAY (in this place): 60
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bannock Mem. Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03 b. COUNTY: Bannock
c. CITY OR TOWN: Pocatello
d. STREET ADDRESS (If rural, give location): 317 So. 12th

3. NAME OF DECEASED (Type or Print): a. (First) ANNA b. (Middle) B. c. (Last) CAPELLEN NUNN

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	July 14, 1892	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Registrar 08	Idaho State Univ.	Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William H. Capellen	Wisconsin	Laura Grace Mendell	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		E. B. Nunn	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1903 Melanoma of Nasal. — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1964 and 1966	Melanoma, malignant	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)
		Pocatello Bannock Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1960 *to* Sept 2 1967 *that I last saw the deceased alive on* Sept 1, 1967, *and that death occurred at* A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. R. Howard M.D.	Pocatello	9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-5-67	Mountainview Cem.	Pocatello, Idaho

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 7 1967	Gloria Depita	John P. Gramm	E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 16 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Crandall

Certificate of Death

STATE OF IDAHO

State File No. 3844
Local Reg. No. 241
Reg. Dist. No. 511

RECEIVED SEP 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
STATE FILE NO. OF STAY (in this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 03 b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Pocatello
d. STREET ADDRESS (If rural, give location) Philbin Road, Rt.1, NO. Box 51

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Community Hosp.

3. NAME OF DECEASED (Type or Print)
a. (First) ERNEST b. (Middle) L. c. (Last) FIALA

4. DATE OF DEATH (Month) (Day) (Year) Sept. 3, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED, (Specify) Married 3
8. DATE OF BIRTH March 22, 1897
9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joe J. Fiala BIRTHPLACE Nebraska
14. MOTHER'S MAIDEN NAME Gusty A. Mizera BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I
16. SOCIAL SECURITY NO. 712-07-6844
17. INFORMANT'S OWN SIGNATURE Mrs. E. L. Fiala ADDRESS Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 3, 1967 *to* Sept 3, 1967 *that I last saw the deceased alive on* Sept 3, 1967, *and that death occurred at* 8:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE W. C. Crandall (Degree or title) MD
23b. ADDRESS Pocatello Idaho
23c. DATE SIGNED Sept 5 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-6-67
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) (State) Pocatello, Idaho

DATE REC'D LOCAL REG. SEP 7 1967
REGISTRAR'S SIGNATURE Gloria Deputa
25. EMBALMER John P. Hamm
LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 28 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 23 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3845
Local Reg. No. 242
Reg. Dist. No. 510

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 420 West Chubbuck Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 947 Taney Lane

3. NAME OF DECEASED (Type or Print)
a. (First): LAEL
b. (Middle): STOKER
c. (Last): WOLFLEY

4. DATE OF DEATH (Month) (Day) (Year): Sept. 4, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: March 1, 1950
9. AGE (In years last birthday): 17 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: High school
11. BIRTHPLACE (State or foreign country): Afton, Wyoming
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lawrence A. Wolfley — BIRTHPLACE: Wyoming
14. MOTHER'S MAIDEN NAME: Ada Ruth Stoker — BIRTHPLACE: Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: 518 60 503
17. INFORMANT'S OWN SIGNATURE: Roger Charles Wolfley — ADDRESS: Pocatello, Ida

18. CAUSE OF DEATH 3220
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Edema, Pulmonary — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Alcoholism, Acute
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from ——, 19—, to ——, 19—, that I ~~last~~ saw the deceased* dead *9-4-1967, and that death occurred at ? m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Burton H. John 583 Coroner
23b. ADDRESS: Bannock Co. Idaho
23c. DATE SIGNED: 9-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Amesville Cemetery
24d. LOCATION (City, town, or county) (State): Etna, Wyoming

DATE REC'D BY LOCAL REG.: SEP 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. . For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3846
Local Reg. No. 243
Reg. Dist. No. 5-10

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN: Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION: 168 Willard Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03 b. COUNTY: Bannock
c. CITY OR TOWN: Pocatello
d. STREET ADDRESS: 168 Willard Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
TERRELL	DON	GENTA	September 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 5	May 17, 1944	23				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Lead-man 06	Bannock Cleaners	Pocatello	Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles A. Genta	Logan, Utah	E. Marie Mortensen	Blackfoot, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	*****	518-52-3221	Mrs. Janice Genta	Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gun shot wound - right temple — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
2 suicide	01 At home	13 Pocatello 031	Bannock	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Sept. 5, 1967 m.		

22. *I hereby certify that I attended the deceased from* [illegible] *to* [illegible] *and that death occurred at* about 1:15a m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583	Bannock County Coroner	Pocatello, Idaho	Sept. 6, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Sept. 8, 1967	Mountainview Cemetery	Pocatello	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 8 1967	[signature]	[signature]	E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 10 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3847
Local Reg. No. 247
Reg. Dist. No. 510

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY in this place: 800
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03 b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 103 East Bryan

3. NAME OF DECEASED (Type or Print): a. (First) MARY b. (Middle) ANN c. (Last) PARKER

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 6, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Nov. 16, 1888

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Escalante, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Preston Allen — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Elizabeth Mitchell — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: XXXX

17. INFORMANT'S OWN SIGNATURE: Fred Allen Parker — ADDRESS: Caldwell, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 2 hr.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Congestive Heart Failure — 4 yrs.

DUE TO (c) Athero sclerotic Heart disease — 4 yrs.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death:* Athero sclerosis. — 4 yrs. / Cerebro vascular Thrombosis — 1 mo.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Strangulated Rt. Femoral Hernia

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 465 M.J.Sharp,M.D.

23b. ADDRESS: 5th & Center, Pocatello, Ida.

23c. DATE SIGNED: 9/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept.9,1967

24c. NAME OF CEMETERY OR CREMATORY: Fielding Mem. Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: SEP 11 1967

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: [signature]

LICENSE NO.: E418

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) After a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3848
Local Reg. No. 2928
Reg. Dist. No. 5-0

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03 b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1437 North Arthur

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MYRON	LESLIE	WESTERN	Sept. 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	5 Married	Sept. 10, 1894	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Manager 26	Purity Biscuit Co.	Deseret, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel W. Western		Mary Alice Hitchinson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Dan A Western	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 18, 19 52, *to* present, 19___, *that I last saw the deceased alive on* Sept. 9, 1967, *and that death occurred at* 10:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. S. Call, M.D.	P. O. Box 852	9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 9, 1967	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 14 1967	Gloria Dopita	T. B. Manning	E418

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician

Certificate of Death

STATE OF IDAHO

State File No. 3849
Local Reg. No. 248
Reg. Dist. No. 511

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN: Pocatello
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Nursing Home 344

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 15
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bancroft
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Hortense	Parke	Lloyd	Sept. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
female	white	widowed 2	Oct. 29, 1882	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	Own home	Salt Lake City, Utah	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Isaac Parke	unknown	Hannah Dover	Australia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Joseph L Lloyd	Bancroft, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardio-Vascular disease — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral accident with coma & paralysis — 9 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-20-, 1967, *to* 9-7-, 1967, *that I last saw the deceased alive on* 9-7, 1967, *and that death occurred at* 2 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David C. Miller MD	Pocatello, Idaho	9/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/11/67	Grace Cemetery	Grace, Idaho

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 13 1967	Glenn Doppke	Leonard Allen	E370

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3850
Local Reg. No. 250
Reg. Dist. No. 511

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Route #2 North

3. NAME OF DECEASED (Type or Print)
a. (First): RONALD
b. (Middle): BLAINE
c. (Last): BENNETT

4. DATE OF DEATH (Month) (Day) (Year): Sept. 7, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: May 6, 1958
9. AGE (In years last birthday): 9 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Public school
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Blaine L. Bennett — BIRTHPLACE: Inkom, Idaho
14. MOTHER'S MAIDEN NAME: Iva Lee Pratt — BIRTHPLACE: Pocatello, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: XXXX
17. INFORMANT'S OWN SIGNATURE: Blaine L. Bennett — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple internal injuries — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Probable intracranial hemorrhage
DUE TO (c) Auto-pedestrian accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 04 Street
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Pocatello, 031 Bannock, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 7, 1967 pm.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: Auto-pedestrian accident

22. *I hereby certify that I attended the deceased from* Sept 7, 1967, *to* Sept 7, 1967, *that I last saw the deceased alive on* Sept 7, 1967, *and that death occurred at* 7:15 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Sydney A. Horrocks, MD 733
23b. ADDRESS: Center Plaza, Pocatello
23c. DATE SIGNED: 9-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: SEP 21 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature]
LICENSE NO.: F418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3851
Local Reg. No. 258
Reg. Dist. No. 510

BIRTH NO.

RECEIVED SEP 18 1967 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY Bannock 03
b. CITY OR TOWN Pocatello
LENGTH OF STAY (in this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1435 No. Arthur Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 03 b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 1435 No. Arthur Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JULIA	HAMP	DUNKEL	Sept. 8 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	Nov. 29, 1885	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Richmond, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ezra T. Hamp	England	Sarah Curtis	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		Mr. Mal Block	Twin Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pulmonary Edema	several days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic heart disease	several yrs.
DUE TO (c)	Hypertensive arteriosclerotic heart disease	several yrs.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct. 2, 1962, *to* Sept. 8, 1967, *that I last saw the deceased alive on* Sept. 8, 1967, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
101 J. E. Comstock	M.D.	P. O. Box 852	9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11 Sep 1967	Mountainview Cem.	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 15 1967	Gloria Depute	George W. Knopp	409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3852
Local Reg. No. 251
Reg. Dist. No. 511

BIRTH NO.

SEP 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Anthony's Mercy Hospt. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 061
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot, (Rural)
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): ROY
b. (Middle):
c. (Last): Johnson

4. DATE OF DEATH (Month) (Day) (Year): Sept. 11, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 4, 1906
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Nels Johnson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Maggie Johnson — BIRTHPLACE: Sweeden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 519-34-8518
17. INFORMANT'S OWN SIGNATURE: Margaret Johnson — ADDRESS: Rt.1, Blackfoot, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

1538

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Colon with Abdominal metastases — INTERVAL BETWEEN ONSET AND DEATH: 4 to 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Sept. 11, 1967, *that I last saw the deceased alive on* Sept 11, 1967, *and that death occurred at* 4.00P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Daniel E. Miller 362 M. D. 1
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Sept 14, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: SEP 21 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Dean Hill — LICENSE NO. E 466

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 3 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 15 1995

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 12 1997

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3853
Local Reg. No. 252
Reg. Dist. No. 510

Certificate of Death

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 726 North 12th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLES
b. (Middle): WILFORD
c. (Last): LOTT

4. DATE OF DEATH (Month) (Day) (Year): Sept. 13, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 4, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardener 04 and
10b. KIND OF BUSINESS OR INDUSTRY: Farmer
11. BIRTHPLACE (State or foreign country): Provo, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Isaiah B. Lott
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Lavonia Andrews

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE — ADDRESS: James L Carney

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 5 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Adenocarcinoma of stomach — 2-1/2 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

151X

19a. DATE OF OPERATION: 3-22-67
19b. MAJOR FINDINGS OF OPERATION: Recurrent adenocarcinoma of stomach
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): no
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 21, 1967, *to* Sept. 13, 1967, *that I last saw the deceased alive on* 9-13, 1967, *and that death occurred at* 2:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M M Graves M D 187
23b. ADDRESS: 1448 East Center, P.O. Box 4084, Pocatello, Ida.
23c. DATE SIGNED: 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sep.16,1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: SEP 21 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 11 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3854
Local Reg. No. 256
Reg. Dist. No. 510

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 9 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (Hours): 200
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1450 East Clark

3. NAME OF DECEASED (Type or Print)
a. (First): ALBERT
b. (Middle): J. 018
c. (Last): HANEY

4. DATE OF DEATH (Month) (Day) (Year): Sept. 16, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov. 20, 1889
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Madison, South Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME BIRTHPLACE: William C. Haney
14. MOTHER'S MAIDEN NAME BIRTHPLACE: Julia Harvey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs Grant Worth — ADDRESS: Pocatello, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

157X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac & renal failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): HSHD
DUE TO (c): Ca pancreas

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 9/5/67
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of the pancreas
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1/67, *19*___, *to* 9/16/67, *19*___, *that I last saw the deceased alive on* 9/16/67, *19*___, *and that death occurred at* 11:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 185 L Horton MD
23b. ADDRESS: 1541 E. Clark St. Pocatello, Idaho
23c. DATE SIGNED: 9/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL: OCT 5 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3855
Local Reg. No. 257
Reg. Dist. No. 510

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 9 1967
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bannock 031	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho 031 b. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello SENGTH OF STAY (In this place): 000	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018	d. STREET ADDRESS (If rural, give location): Fargo Apartments

3. NAME OF DECEASED (Type or Print)	a. (First): EVAN	b. (Middle): W.	c. (Last): EVANS	4. DATE OF DEATH (Month) (Day) (Year): September 17 1967
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married	8. DATE OF BIRTH: August 26, 1920	9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24	10b. KIND OF BUSINESS OR INDUSTRY: Real Estate	11. BIRTHPLACE (State or foreign country): Pocatello Idaho	12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Clyde W. Evans	BIRTHPLACE: Kansas	14. MOTHER'S MAIDEN NAME: Grace Butz	BIRTHPLACE: Iowa	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War II 4	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Clyde E. Evans	ADDRESS: Pocatello, Idaho	

331X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Right subdural hematoma — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) unknown — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 13, 1967, *to* Sept. 17, 1967, *that I last saw the deceased alive on* Sept. 17, 1967, *and that death occurred at* 5:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: L Henderson (Degree or title) 009	23b. ADDRESS: Pocatello, Idaho	23c. DATE SIGNED: Sept. 20, 1967	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept. 20, 1967	24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery	24d. LOCATION (City, town, or county) (State): Pocatello Idaho
DATE REC'D BY LOCAL REG.: OCT 1 1967	REGISTRAR'S SIGNATURE: Gloria Dopita	25. EMBALMER: Jack Henderson	LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3856
Local Reg. No. 253
Reg. Dist. No. 511

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock — SEP 25 1967 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello — Bureau of Vital Statistics
c. LENGTH OF STAY (If outside place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Reservation & Hawthorne Roads

3. NAME OF DECEASED (Type or Print)
a. (First): ROSELLA
b. (Middle):
c. (Last): CUTLER

4. DATE OF DEATH (Month) (Day) (Year): Sept. 18, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married
8. DATE OF BIRTH: Feb. 23, 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Stone, Kentucky
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: William Ball
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Lavicy May

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Joe Cutler — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Hypertensive Cardio-Vascular — INTERVAL BETWEEN ONSET AND DEATH: yes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Disease = Myocardial Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Morbid obesity — yes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 9-18-, 1967, *that I last saw the deceased alive on* 9-6-, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 362 David C. Miller, MD-1
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 9-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: SEP 21 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3857
Local Reg. No. 255
Reg. Dist. No. 512

BIRTH NO.

RECEIVED SEP 27 1967 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place): 100
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) SARAH; b. (Middle) JANE; c. (Last) AUSTIN

4. DATE OF DEATH: (Month) Sept. (Day) 18, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	Dec. 12, 1873	93				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Liberty, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Evan Samuel Morgan — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Margaret Roberts — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): XXXXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE — ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4508 Uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1958, 19__, *to* 9/18, 1967, *that I last saw the deceased alive on* 9/17, 1967, *and that death occurred at* 12:05 a *m., from the causes and on the date stated above.*

23a. SIGNATURE: George Allen (Degree or title) MD — 23b. ADDRESS: Pocatello, Idaho — 23c. DATE SIGNED: 9/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: Sept. 20, 1967 — 24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery — 24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: SEP 25 1967 — REGISTRAR'S SIGNATURE: Gloria Doyle — 25. EMBALMER: T. B. Manning — LICENSE NO.: E418

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3858
Local Reg. No. 279
Reg. Dist. No. 511

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock — OCT 19 1967 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 030
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital 030

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 030
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): DOCTOR
b. (Middle): WARREN
c. (Last): BLOXHAM

4. DATE OF DEATH (Month) (Day) (Year): Sept. 20, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 15, 1877
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Downey, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Bloxham — BIRTHPLACE: Downey
14. MOTHER'S MAIDEN NAME: Alice Hill — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown
16. SOCIAL SECURITY NO.: 519 42 9692
17. INFORMANT'S OWN SIGNATURE: Lurie Bybee — ADDRESS: Downey

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9037

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Had fall fractured Hip

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): XX 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Rest Home 13
21c. (CITY, TOWN, OR TOWNSHIP) 030 (COUNTY) (STATE): 13 Lava Hot Springs, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 8-16-67 11p m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fell getting out of bed

22. *I hereby certify that I attended the deceased from* _____ *19*__ *to* Sept, 1967, *that I last saw the deceased alive on* Sept 1, 1967, *and that death occurred at* 8:45 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 070 (Degree or title)
23b. ADDRESS: Downey Idaho
23c. DATE SIGNED: 10/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cambridge Cemetery
24d. LOCATION (City, town, or county) (State): Cambridge, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 17 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 9 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3859
Local Reg. No. 258
Reg. Dist. No. 510

RECEIVED OCT 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (If hospital or institution): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 326 Yellowstone

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NORMAN	ELLIS	MANION	Sept. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Jan. 18, 1890	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Gas fitter	City Gas Co.	Lathrop, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard F. Manion		Mary Pruitt	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX	519 09 8057A	Mary E. Manion	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Acute respiratory insufficiency	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Pulmonary emphysema and fibrosis	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug, 1966, *to* Sept 20, 1967, *that I last saw the deceased alive on* Sept 20, 1967, *and that death occurred at* 10:32 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. Henderson	MD	Pocatello, Idaho	25 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 23, 1967	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEP 29 1967	Gloria Smith	T. D. Wilson	E418

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-8515

BIRTH NO.

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3860
Local Reg. No. 267
Reg. Dist. No. 510

OCT 12 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF DEATH (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): MICHELE
b. (Middle): ELISE 018
c. (Last): REYNOLDS

4. DATE OF DEATH (Month) (Day) (Year): Sept. 26, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: Sept. 24, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 2; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: XXXXXX
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael Brent Reynolds — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Victoria Eve Richardson — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: XXXX
17. INFORMANT'S OWN SIGNATURE: Michael B. Reynolds — ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

750X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): anencephalia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 24, 1967, *to* Sept 26, 1967, *that I last saw the deceased alive on* Sept 26, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David M Jonesmith 266
23b. ADDRESS: 527 South 12th Pocatello Idaho
23c. DATE SIGNED: 10/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 27, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 11 1967
REGISTRAR'S SIGNATURE: Florence Dopita
25. EMBALMER: [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Manning Funeral Chapel

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3861
Local Reg. No. 263
Reg. Dist. No. 511

RECEIVED OCT 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN: Pocatello
c. LENGTH OF STAY IN (this place): 1½ mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bannock Memorial Hosp. 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 030
b. COUNTY: Bannock 201
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL--Ft. Hall
d. STREET ADDRESS (If rural, give location): Rio Vista Rd.

3. NAME OF DECEASED (Type or Print): a. (First) HARRY b. (Middle) c. (Last) PONZO

4. DATE OF DEATH: (Month) Sept. (Day) 28 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: Indian 3
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 1, 1881
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer--Stockman 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Salmon, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ponzo — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Jennie Cooee — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-38-9055
17. INFORMANT'S OWN SIGNATURE: Dolly M Ponzo — ADDRESS: Ft Hall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) hemorrhagic diathesis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) severe liver disease
DUE TO (c) and renal disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus arteriosclerosis generalized

5-83X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* Sept 28, 1967, *that I last saw the deceased alive on* Sept 27, 1967, *and that death occurred at* — m., *from the causes and on the date stated above.*

23a. SIGNATURE: Calvin Burkholder M.D. (Degree or title)
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cedars Cemetery
24d. LOCATION (City, town, or county) (State): Ft. Hall Idaho

DATE REC'D BY LOCAL REG.: OCT 9 1967
REGISTRAR'S SIGNATURE: Gloria Ponzo
25. EMBALMER: George A Kroff
LICENSE NO.: 409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3862
Local Reg. No. 264
Reg. Dist. No. 5-16

RECEIVED OCT 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03 307
b. CITY OR TOWN (If outside corporate limits, write township): Pocatello
LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 926 E. Bonneville

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ADA	NORRIS	SMITH	Sept. 28 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Sept. 27, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
X Secretary 19	Appliance Co.	London, England	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John H. Norris	England	Alice Atkins	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-05-3487	Elmer V. Smith	Pocatello Idaho

2040

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute lymphatic leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 or 3 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) chronic lymphatic leukemia — app.10 mo.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease with angina pectoris — several yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-5 *,* 19 57 *, to* 9-28 *,* 19 67 *, that I last saw the deceased alive on* 9-28 *,* 67 *, and that death occurred at* 7:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J.E. Comstock, M.D.	P. O. Box 852	10-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 2, 1967	Mountainview Cem.	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 9 1967	Gloria Davis	George W. Zaff	409

FIRM NAME: Downard Funeral Home.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3863
Local Reg. No. 259
Reg. Dist. No. 5 11

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock — OCT 9 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
c. LENGTH OF STAY (in this place): 30
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 030
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
d. STREET ADDRESS (If rural, give location): --- SPOUSE: Lillie Orissa Criddle

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
SEVEREN	LE ROY	SALVESEN	SEPT	29	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married	June 4, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Hyrum, Cache, Utah	U.S.A.

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
George S. Salvesen - Kristiansand, Norway	Elizabeth Ardirck Johnson - Skull Valley, Ut

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-	518-16-5053	Elayne J. Salvesen	Downey, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Gall Bladder — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) & Metastasis to liver

DUE TO (c) & Jaundice

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4-24-67	Carcinoma of Gall Bladder Metastatic mass liver	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1957, 19__, *to* Sept 29, 1967, *that I last saw the deceased alive on* Sept. 29, 1967, *and that death occurred at* 7:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl Rathe M.D.	Downey, Idaho	10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	Oct. 2, 1967	Downey City Cemetery	Downey	Bannock Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 23 1967	Elona Pratt	Ralford G. Benson	E-351

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 25 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3864
Local Reg. No. 265
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
OCT 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 131 North Ninth Avenue

3. NAME OF DECEASED (Type or Print): a. (First) IRENE b. (Middle) ANGELO 019 c. (Last) REDDY

4. DATE OF DEATH (Month) (Day) (Year): September 30, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 5

8. DATE OF BIRTH: October 9, 1898

9. AGE (In years last birthday): 68 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Montpelier, Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Joseph Fuller — BIRTHPLACE: Pennsylvania

14. MOTHER'S MAIDEN NAME: Nellie O'Doyle — BIRTHPLACE: St. Louis, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): ****

16. SOCIAL SECURITY NO.: 443X

17. INFORMANT'S OWN SIGNATURE: E. Reddy — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardiovascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: yrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) —

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Severe arthritis — yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1952, 19___, *to* Sept. 30, 19 67, *that I last saw the deceased alive on* Sept. 30, 19 67, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David E. Miller M.D. — **23b. ADDRESS**: Pocatello, Idaho — **23c. DATE SIGNED**: Oct. 2, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Oct. 3, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Mountainview Cemetery — **24d. LOCATION** (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: OCT 9 1967 — **REGISTRAR'S SIGNATURE**: Glenn Smith — **25. EMBALMER**: Jack Henderson — **LICENSE NO.**: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

DUTIES:

OCT 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 16 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 24 1993

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3865
Local Reg. No. 260
Reg. Dist. No. 510

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock — OCT 9 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello — LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 5555 Yellowstone

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ARVIN	JOHN "JOCK"	BELL	Sept. 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	April 29, 1908	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Construction and	Trailer Court	Lava Hot Springs, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Bell	Franklin, Idaho	Effie Avery	Central, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	XXXX		Lary Bell	Idaho Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 1952, 19__, to ____, 19__, that I last saw the deceased alive on Sept 30, 1967, and that death occurred at 11:32 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald C. Miller M.D.	Pocatello Idaho	10-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 3, 1967	Lava Hot Springs Cem.	Lava Hot Springs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 5 1967	Gloria Dante	[signature]	EH18

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3866
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED SEP 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040 b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Ida. c. LENGTH OF STAY (in this place) 23 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home 007

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 040 b. COUNTY Bear Lake 007 c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho
d. STREET ADDRESS (If rural, give location) 744 Front St.

3. NAME OF DECEASED (Type or Print) a. (First) Paul b. (Middle) Rich c. (Last) Gunderson

4. DATE OF DEATH (Month) (Day) (Year) Sept 2 1967

5. SEX Male 6. COLOR OR RACE White 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 8. DATE OF BIRTH Aug. 17 1944 9. AGE (In years last birthday) 23 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee of First Security Bank 10b. KIND OF BUSINESS OR INDUSTRY Bank 11. BIRTHPLACE (State or foreign country) Montpelier Idaho 12. CITIZEN OF WHAT COUNTRY U.S.A.

13. FATHER'S NAME Lester F Gunderson BIRTHPLACE St Charles Ida 14. MOTHER'S MAIDEN NAME Ora Rich BIRTHPLACE Paris Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. 519-52-6747 17. INFORMANT'S OWN SIGNATURE Lester F Gunderson ADDRESS Montpelier Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cystic Fibrosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
(a) 1 mo.
(b) ?
(c)

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION 20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20, 1967 *to* 9-2, 1967, *that I last saw the deceased alive on* 9-2, 1967, *and that death occurred at* 9 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 23b. ADDRESS 23c. DATE SIGNED 9-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE Sept 6 1967 24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery 24d. LOCATION (City, town, or county) Montpelier (State) Idaho

DATE REC'D BY LOCAL REG. 9-7-67 REGISTRAR'S SIGNATURE Mrs Ruby Gotcsik 25. EMBALMER Dale Matthews LICENSE NO. E959

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service
Form OH-60021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3867
Local Reg. No.
Reg. Dist. No. 552

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Georgetown
c. LENGTH OF STAY (in this place) 007
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at Home 007

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 040 b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Georgetown Idaho.
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Hannah b. (Middle) Smart c. (Last) Hayes

4. DATE OF DEATH (Month) (Day) (Year) Sept 4 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH July 27 1893

9. AGE (In years last birthday) 74 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Avid Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Abel Smart | BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Anna C. Jensen | BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-48-9091

17. INFORMANT'S OWN SIGNATURE Mrs Duane Johnson | ADDRESS Layton Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7824

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Died in her Sleep

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* —— m., *from the causes and on the date stated above.*

23a. SIGNATURE Dale Matthews (Degree or title) 583 Coroner

23b. ADDRESS Montpelier Idaho

23c. DATE SIGNED 9/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept 7 1967

24c. NAME OF CEMETERY OR CREMATORY Georgetown Cemetery

24d. LOCATION (City, town, or county) Georgetown (State) Idaho

DATE REC'D BY LOCAL REG. 9/5/67

REGISTRAR'S SIGNATURE Mrs Ruby Gotcewsky

25. EMBALMER Dale Matthews

LICENSE NO. E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-6302A

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3868
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

SEP 21 1967

040 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 040 b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho
d. STREET ADDRESS (If rural, give location) 343 Beckwith St.

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Horsfall c. (Last) Robinson

4. DATE OF DEATH (Month) Sept (Day) 7 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Mar 15 1905

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher & Meat

10b. KIND OF BUSINESS OR INDUSTRY Cutter

11. BIRTHPLACE (State or foreign country) Evanston Wyoming

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Robinson BIRTHPLACE Wanship Ut.

14. MOTHER'S MAIDEN NAME Mary Jane Peterson BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-07-6899

17. INFORMANT'S OWN SIGNATURE Mrs Thelma Robinson ADDRESS Montpelier

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonitis + Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Congestive Heart failure

DUE TO (c) Arteriosclerosis 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 1, 1967, to Sept 7, 1967, that I last saw the deceased alive on Sept 7, 1967 and that death occurred at 4:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) — 23b. ADDRESS Montpelier Idaho — 23c. DATE SIGNED 9-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE Sept 9 1967 — 24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery — 24d. LOCATION (City, town, or county) (State) Montpelier Idaho

DATE REC'D BY LOCAL REG. 9-13-67 — REGISTRAR'S SIGNATURE Mrs Ruby Gortsema

25. EMBALMER Mike Matthews — LICENSE NO. E 359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 19 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3869
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake 040 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho
c. LENGTH OF STAY (in this place) 7 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 040
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dingle Idaho.
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle) Warren
c. (Last) Sirrine

4. DATE OF DEATH (Month) (Day) (Year) Sept. 26, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug 24 1888
9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired County Assessor
10b. KIND OF BUSINESS OR INDUSTRY B.L. County
11. BIRTHPLACE (State or foreign country) Dingle Idaho.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George E. Sirrine
BIRTHPLACE California
14. MOTHER'S MAIDEN NAME Sarah Oakey
BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-16-6691A
17. INFORMANT'S OWN SIGNATURE Mrs Arvilla Sirrine
ADDRESS Dingle Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Uremia — 1 mo.
DUE TO (c) Multiple Small Strokes — 2-3 mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-4, 1961, *to* 9-26, 1967, *that I last saw the deceased alive on* 9-26, 1967, *and that death occurred at* 12:20 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE Paul F. Clevenger M.D. (Degree or title)
23b. ADDRESS Mont. Idaho
23c. DATE SIGNED 9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 29 1967
24c. NAME OF CEMETERY OR CREMATORY Dingle Cemetery
24d. LOCATION (City, town, or county) (State) Dingle Idaho

DATE REC'D BY LOCAL REG. 9-28-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinski
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 3870
Local Reg. No. 34
Reg. Dist. No. 130

Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY (in this place): 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Community Hospital 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 050
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
d. STREET ADDRESS (If rural, give location): 231 13th. Street

3. NAME OF DECEASED (Type or Print)
a. (First): Hannah
b. (Middle): Charlotte
c. (Last): Kendall

4. DATE OF DEATH (Month) (Day) (Year): September 1 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: January 1, 1879
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Denmark
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: B Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-60-9877
17. INFORMANT'S OWN SIGNATURE: Bernice Kendall King — ADDRESS: 1066 W. 9th Coquille Ore

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 mo

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis — Unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Hypostatic Pneumonia — 1 wk
Fractured l. arm & pelvis — 1 mo

19a. DATE OF OPERATION: 8-2-67
19b. MAJOR FINDINGS OF OPERATION: Reduction fractures l. arm 8-9-67 open reduction [illegible]
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 1, 1967, *to* Sept 1, 1967, *that I last saw the deceased alive on* Sept 1, 1967, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. F. Thiessen 533 MD
23b. ADDRESS: St. Maries Idaho
23c. DATE SIGNED: 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/5/1967
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24d. LOCATION (City, town, or county) (State): St. Maries, Idaho

DATE REC'D BY LOCAL REG.: 9-13-67
REGISTRAR'S SIGNATURE: Wanda Olimico
25. EMBALMER: David O. Hansen
LICENSE NO.: E-510

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3871
Local Reg. No. 35
Reg. Dist. No. 130

RECEIVED Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewah SEP 25 1967 050 50
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emida
LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hwy. 95A Emida 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 05 b. COUNTY Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emida
d. STREET ADDRESS (If rural, give location) (None) PO Box 15

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Clinton	Edward	Spalding	September 2 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	March 18, 1908	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Road Work //	Foreman	California	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wilber F. Spalding	California	Annie Belle McCloud	Nova Scotia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	557-09-0922	Burton A Spalding	7960 Archer Fair Oaks, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion	15 min
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis	Unknown
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Emphysema	2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* 9-2, 1967, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 7P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. D. Thurston MD	St. Maries, Idaho	9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/6/1967	Woodlawn Cemetery	St. Maries, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-13-67	Wanda Simmons	David O. Hansen	E-510

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3872
Local Reg. No. 33
Reg. Dist. No. 130

RECEIVED SEP 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1.5Mi. N. Tensed
c. LENGTH OF STAY (in this place): few min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway #95 007

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 01
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 30 Mesa Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Michael	Dropping	Sept. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	Feb. 15, 1948	19		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	U. of Idaho	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Anton Dropping	Minn.	Petranella Kotula	Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	----------	Unknown	[signature]	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	INTERVAL BETWEEN ONSET AND DEATH
	Multiple rib fractures	Instant
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	
	DUE TO (c)	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture cervical spine	Instant

8354

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION: 20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 95	Plummer Benewah Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Sept 10, 1967 6A m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Car accident

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 6:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B.A. Rapp 428 M.D.	St. Maries, Idaho	9-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-13-67	Cloverdale Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-19-67	[signature]	Gerald Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 28 1967

MAR 22 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3873
Local Reg. No. 31
Reg. Dist. No. 130

BIRTH NO.

RECEIVED SEP 25 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL): 1½ mi N. Tensed
c. LENGTH OF STAY (In this place): Two months
d. FULL NAME OF HOSPITAL OR INSTITUTION: Highway # 95

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 1336 4th Ave. East

3. NAME OF DECEASED (Type or Print): a. (First) Jeffrey b. (Middle) c. (Last) Toler

4. DATE OF DEATH (Month) (Day) (Year): September 10, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: October 21, 1948

9. AGE (In years last birthday): 18
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: G.W. Toler — BIRTHPLACE: Arapahoe, Nebraska

14. MOTHER'S MAIDEN NAME: Betty L. Judy — BIRTHPLACE: Torrington, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-54-8064

17. INFORMANT'S OWN SIGNATURE: Twin Falls, ADDRESS Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Compound skull fracture — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) frontal region

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway

21c. (CITY, TOWN, OR TOWNSHIP) Plummer (COUNTY) Benewah (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 10, 1967 6A

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Car accident

22. *I hereby certify that I attended the deceased from* DOA, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 6 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: B. A. Rapp M.D. (Degree or title) Cornner

23b. ADDRESS: St. Maries Idaho

23c. DATE SIGNED: 9-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 9/10/67

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 9-19-67

REGISTRAR'S SIGNATURE: Vanda Dimico

25. FUNERAL DIRECTOR: Gerald Browning — ADDRESS: St. Maries Idaho

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

OCT 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 3874
Local Reg. No. 32
Reg. Dist. No. 130

RECEIVED SEP 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 1.5 Mi. N. Tensed
c. LENGTH OF STAY (in this place): few Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway #95

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington
b. COUNTY: Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): South 2518 Sunrise Road

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Daron	Mark	Bell	Sept. 10 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	Oct. 26, 1947	19		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	Univ. of Idaho	Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert C. Bell	Boise Idaho	Beatrice Manville	Omaha Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No None	532-48-6621	Robert C. Bell	S. 2518 Sunrise Rd - Spokane, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of the aorta — Interval between onset and death: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Penetrating wound of chest
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture femur

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Highway 95	Plummer Benewah Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
9 - 10 - 67 6 10 A.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	

22. *I hereby certify that I attended the deceased from* DOA, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. A. Rapp 428 M.D.	St. Maries, Idaho	9-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-13-67	Greenwood Cemetery	Spokane Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-20-67	Standard Director	Darrell Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3875
Local Reg. No. 36
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah — SEP 22 1967 — 050 — 508
b. CITY OR TOWN: 2.5 Mi. North Tensed — Bureau of Vital Statistics — c. LENGTH OF STAY (in this place): few min
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway #95 — 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 46 Washington — b. COUNTY: 555 King
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Seattle
d. STREET ADDRESS (If rural, give location): 519 West Prospect

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Leonard	Clyde	McMahan	Sept.	11	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	January 13, 1912	55				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Engineer 21	Boeing	Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Leonard Clyde McMahan	Iowa	Claribel Poler	Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	537-01-2751	George M Poler	Pullman, Wash

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Fracture cervical spine — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Facial lacerations

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Highway 95	Plummers 050	Benewah	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Sept	11	1967	3P m.		Car accident

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 3:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B. A. Rapp 428 M.D.	St. Maries, Idaho	9-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Removal	9-12-1967	West Home Funeral Chapel	Seattle	Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-19-67	Standard Clinic	Gerald Browning	E-411

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 20 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

SEP 2 5 1967

Bureau of Vital Statistics

State File No. 3876
Local Reg. No. 37
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewah 050 312
b. CITY OR TOWN St. Maries
c. LENGTH OF STAY (in this place) 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Comm. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 050 Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fernwood
d. STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print) a. (First) Jesse b. (Middle) H. c. (Last) James

4. DATE OF DEATH (Month) (Day) (Year) Sept. 12 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced
8. DATE OF BIRTH Dec. 27 1883
9. AGE (In years last birthday) 83
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY Sawmill
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 445-05-3233
17. INFORMANT'S OWN SIGNATURE Mrs. N.C. McCall ADDRESS Fernwood

18. CAUSE OF DEATH 3318
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-30, 1967, to 9-12, 1967, that I last saw the deceased alive on 9-11, 1967, and that death occurred at 5:45 p.m., from the causes and on the date stated above.

23a. SIGNATURE W.D. Thurston (Degree or title) MD 533
23b. ADDRESS St. Maries, Idaho
23c. DATE SIGNED 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-15-67
24c. NAME OF CEMETERY OR CREMATORY Woodlawn
24d. LOCATION (City, town, or county) St. Maries (State) Idaho

DATE REC'D BY LOCAL REG. 9-19-67
REGISTRAR'S SIGNATURE Vanda Dimick
25. EMBALMER Jerrell Browning LICENSE NO. E-411
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

JUN 30 [illegible]

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3877
Local Reg. No. 38
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BENEWAH 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SANDERS (RURAL)
c. LENGTH OF STAY (in this place): 27 YRS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): — 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 050
b. COUNTY: BENEWAH
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SANDERS (RURAL)
d. STREET ADDRESS (If rural, give location): —

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry	OLIVER	Larson	SEPT. 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED 3	JAN. 16, 1885	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER 04	GRAIN FARM OWNER	ST. JAMES, MINN.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
OLE S. LARSON	NORWAY	MARY HANSON	NORWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		518-42-5218	Vernon Larson	Deshet Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Thrombosis
DUE TO (c) Atherosclerotic heart disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCoccur?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* August 3, 1967, *and that death occurred at* 7:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Shirley O. Thiel	M.D.	Fairfield, Wa. 99012	Sept 25, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	SEPT. 28, 1967	FAIRVIEW CEMETERY	ROCKFORD, WASH.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR ADDRESS
9-29-67	Wanda Simms	JAEGER FUNERAL HOME - ROSALIA, WASH.

Federal Security Agency
United States Public Health Service

Form DPH-48021

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 2 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

STATE OF IDAHO

State File No. 3878
Local Reg. No. 39
Reg. Dist. No. 130

BIRTH NO.

RECEIVED
OCT 11 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY IN THIS PLACE: 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Community Hospital 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 050
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
d. STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Julia	Elizabeth	Kinsolving	September 25 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Nov. 16, 1887	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Virginia	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Oscar Britton Eanes	Virginia	Julia Edwin Wilkinson	Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-22-5715	C. Kinsolving M.D.	Route 2. St. Maries, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Vascular Accident	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerosis	Unknown
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

331X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-22, 1967, *to* 9-25, 1967, *that I last saw the deceased alive on* 9-25, 1967, *and that death occurred at* 9:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. J. Thurston 533 MD	St. Maries, Idaho	9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 28, 1967	Woodlawn Cemetery	St. Maries, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-4-67	Wanda Simmons	Gerald E. Browning	E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3879
Local Reg. No. 40
Reg. Dist. No. 130

RECEIVED
OCT 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050 101
b. CITY OR TOWN (If outside corporate limits, write RURAL): St. Maries
LENGTH OF STAY (in this place): 1 Month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Community Hospital 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 050
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
d. STREET ADDRESS (If rural, give location): 403 10th. St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
James	Boyd	Booth	September 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	July 3, 1907	60		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Inspector (car) 70	Railroad	Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Booth	Iowa	Eva Mae Rogers	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-03-8314	Mrs J Boyd Booth	St. Maries, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema & Hernia 1 yr.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* 9-22, 1967, *that I last saw the deceased alive on* 9-22, 1967, *and that death occurred at* 9:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W.D. Thrasher M.D.	St. Maries, Idaho	10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/30/1967	Woodlawn Cemetery	St. Maries, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-4-67	Wanda Simms	David A. Hansen	E-510

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Browning Funeral Home

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3880
Local Reg. No. 105
Reg. Dist. No. 600

RECEIVED SEP 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061 118
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 18 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 349 South Adams 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 061
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 349 South Adams

3. NAME OF DECEASED (Type or Print)
a. (First): FERN
b. (Middle): ELAINE
c. (Last): GIBB

4. DATE OF DEATH (Month) (Day) (Year): September 1, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: November 19, 1908
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewwife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Peabody, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John H. Glick — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Lucy Graves — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 544-20-9356
17. INFORMANT'S OWN SIGNATURE: Lamar D. Gibb — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8910

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carbon Monoxide Poisoning — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Bumped head + dazed herself after
DUE TO (c): Car was started, overcome by exhaust fumes.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home-garage 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Blackfoot, 061 Bingham Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 1, 1967 11:45 a.m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Overcome with fumes from auto exaust. Garage doors were closed.

22. *I hereby certify that I attended the deceased from* September 1, 19 67, *to* xxxxxxxxxxxxx, *that I last saw the deceased alive on* xxxxxxxxxxxxx, *and that death occurred at* 12:30p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Carl Stoler 583 4 (Degree or title): Coroner Bingham
23b. ADDRESS: county Blackfoot, Idaho
23c. DATE SIGNED: Sept 2, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 5, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: C. Dean Hill — LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 12 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 17 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3881
Local Reg. No. 122
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Firth
c. LENGTH OF STAY (in this place) 002
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 001

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060 b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Firth,
d. STREET ADDRESS (If rural, give location) Rt. 1 Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Cyprien		Gentillon	9	2	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc	Married 3	Feb. 24, 1888	79 Yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer- Retired 04		Molene Champour, France	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Isadore Gentillon	France	Marianne	France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI	518-42-7604 A		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 1-2 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug 29, 1967, to Sept 2, 1967, *that I last saw the deceased alive on* Aug 29, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gary L. Nalder MD	625 W. Pacific Blvd.	10-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 6, 1967	Riverview	Firth Bingham Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-67	Dorothy J. Jones	Gary L. Nalder Gary L Nalder	444

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Nalder Funeral Home

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3882
Local Reg. No. 108
Reg. Dist. No. 600

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061 209
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 9 mo. 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
d. STREET ADDRESS (If rural, give location): Box 471

3. NAME OF DECEASED (Type or Print)
a. (First): Alvin
b. (Middle): F.
c. (Last): Young

4. DATE OF DEATH (Month) (Day) (Year): Sept. 6, 1967

5. SEX: M
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 6 January 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 516-09-5368
17. INFORMANT'S OWN SIGNATURE: Medical Records State Hosp. La Dene Hansen, RN — ADDRESS: South

18. CAUSE OF DEATH 4918
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Pulmonary Pneumonia -Edema — 9 days
DUE TO (c): Acute Bronchopneumonia — 6 days.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 30 Nov., 1966, *to* 6 Sept, 1967, *that I last saw the deceased alive on* 6 Sept, 1967, *and that death occurred at* 10:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O. G. Stillinger M 594
23b. ADDRESS: Blackfoot, Box 390 Idaho
23c. DATE SIGNED: 6 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept 12, 1967
24c. NAME OF CEMETERY OR CREMATORY: Wendell cemetery
24d. LOCATION (City, town, or county) (State): Wendell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 15, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Dean Hill
LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 17 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUN 14 1977

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3883
Local Reg. No. 107
Reg. Dist. No. 600

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): AGNES
b. (Middle): D.
c. (Last): DeCOLA

4. DATE OF DEATH (Month) (Day) (Year): September 9, 1967

5. SEX: female
6. COLOR OR RACE: Indian 3
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: January 19, 1916
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary 19
10b. KIND OF BUSINESS OR INDUSTRY: Ft. Hall Indian Agency
11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Thorpe — BIRTHPLACE: Montanan
14. MOTHER'S MAIDEN NAME: Josephine Meeks — BIRTHPLACE: McCall, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 539-16-1557
17. INFORMANT'S OWN SIGNATURE: Alexander DeCola — ADDRESS: Fort Hall, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4331

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Embolism

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Auricular Fibrilation
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Left Hemiplegia

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 27 1967, *to* Sept 9, 1967, *that I last saw the deceased alive on* Sept 9, 1967, *and that death occurred at* 8:30p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A E Miller Sr 360 M.D. 1
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Sept 14, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Sept. 15, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Dean Hill
LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 26 1967

APR 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 25 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3884
Local Reg. No. 111
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham (061)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
LENGTH OF STAY (in this place): 007
d. FULL NAME OF HOSPITAL OR INSTITUTION: 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho (420) b. COUNTY: T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hansen
d. STREET ADDRESS (If rural, give location): 120 1st Street East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	EDWARD	GARRETT	POST	September 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married (3)	November 29, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Mechanic (21)	Auto	Logan, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George G. Post	Wisconsin	Emma Bleidissel	Seneca, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W.#1 (3)	509-07-4107	Donald E. Post	Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Brain damage — INTERVAL, BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Car accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	(06)	2 1/2 Miles N. Blackfoot I-15 (06) Bingham Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
09	11	67	9:½ A.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Car accident

22. *I hereby certify that I attended the deceased from* Sept 11, 19 67, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl Staley (583)	Coroner	321 E. Walker Blackfoot	9-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	9/11/67	Centralia Cemetery	Centralia, Oklahoma

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Sept. 15, 1967	Dorothy J. James	Logan Hill Sandley-Hill	Blackfoot Idaho

Federal Security Agency
United States Public Health Service

Form DPH-48021

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Mrs Fack

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3885
Local Reg. No. 110
Reg. Dist. No. 601

BIRTH NO.

SEP 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Rural~~ Hansen
d. STREET ADDRESS (If rural, give location): 120 1st Street East

3. NAME OF DECEASED (Type or Print)
a. (First): HAZEL L.
b. (Middle): JOHNSON
c. (Last): POST

4. DATE OF DEATH (Month) (Day) (Year): September 11, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 21, 1910
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Annis, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ira A. Hall — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Lucy V. Park — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-40-1992
17. INFORMANT'S OWN SIGNATURE: Hansen, Doris Mothershead — ADDRESS: Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Severe Brain damage — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Car accident

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 2 mile N. I-15 Blackfoot 061 Bingham Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9 11 67 9:30 A m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__ *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

I did not see her alive

23a. SIGNATURE (Degree or title): Carl Staley 583 Coroner 4
23b. ADDRESS: 321 E. Walker Blackfoot
23c. DATE SIGNED: 9-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/14/67
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 15, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. FUNERAL DIRECTOR: C. Dean Hill Sandberg-Hill — ADDRESS: Blackfoot Ida.

Federal Security Agency
United States Public Health Service

Form DPH-48021

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3886
Local Reg. No. 715
Reg. Dist. No. 600

BIRTH NO.

RECEIVED OCT 4 1967 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Blackfoot,
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blackfoot, Memorial Hosp 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingahm
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Firth,
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Alford b. (Middle) W. c. (Last) Armstrong

4. DATE OF DEATH: (Month) Sept (Day) 13 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Devorced

8. DATE OF BIRTH: Nov 30 1887

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Walsburg Utah

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Henry Armstrong — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Elizabeth Harriet Robinson — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 721 14 2209

17. INFORMANT'S OWN SIGNATURE: Earl Armstrong — ADDRESS:

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Diabetes mellitus — Unknown

Generalized arteriosclerosis — 10 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19 63, *to* Sept 13, 19 67, *that I last saw the deceased alive on* Sept 13, 19 67, *and that death occurred at* 2 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Emerson Packer MD 404

23b. ADDRESS: Blackfoot Idaho

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-16-67

24c. NAME OF CEMETERY OR CREMATORY: Firth,

24d. LOCATION (City, town, or county) (State): Firth, Bingham Idaho

DATE REC'D BY LOCAL REG.: Sept 26 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Floyd W. Walden — LICENSE NO.: E275

FIRM NAME: Walden's Funeral Home Shelley, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3887
Local Reg. No. 189
Reg. Dist. No. 601

Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall reservation
c. LIMITS OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fort Hall Reservation 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural (Fort Hall)
d. STREET ADDRESS (If rural, give location): Fort Hall reservation

3. NAME OF DECEASED (Type or Print)
a. (First): MARGARET
b. (Middle): Nevada
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Found September 13, 1967

5. SEX: female
6. COLOR OR RACE: Indian 3
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: December 25, 1925
9. AGE (In years last birthday): 41 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Fort Hall, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel Nevada — BIRTHPLACE: Salmon, Idaho
14. MOTHER'S MAIDEN NAME: Annie Tyler — BIRTHPLACE: Salmon, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT'S OWN SIGNATURE: Fort Hall Indian Agency records — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowning — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fellin canal - striking left side on
DUE TO (c): Concrete, knocking herself unconscious

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 1 Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 18 13
21c. (CITY, TOWN, OR TOWNSHIP): S.W. Blackfoot 061 — (COUNTY): Bingham — (STATE): Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased* ~~from~~ September 13, 1967, ~~to xxxxxxxxxxxx, 19xxx, that I last saw the deceased alive on xxxxxxxxxxxx, 19xxx~~, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Carl Staley 583 — (Degree or title): Coroner, Bingham county
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Sept 15, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cedars cemetery
24d. LOCATION (City, town, or county): Fort Hall reservation — (State): Idahp

DATE REC'D BY LOCAL REG.: Sept. 15, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: C. Dean Hill — LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 25 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3888
Local Reg. No. 113
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 06 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 11Mo22 D
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16 2 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) James Joseph b. (Middle) c. (Last) Spence

4. DATE OF DEATH (Month) (Day) (Year) Sept. 14, 1967

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 22

8. DATE OF BIRTH 5 Dec. 1891

9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) California

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John. Spence BIRTHPLACE California

14. MOTHER'S MAIDEN NAME Margaret Anderson BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S SIGNATURE L. Hansen, RN ADDRESS State Hospital South Blackfoot

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the bladder — INTERVAL BETWEEN ONSET AND DEATH: unknown months to years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cause unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Pathological fracture of right hip
Arteriosclerosis, generalized

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 Sept, 19 67, *to* 14 Sept, 1967, *that I last saw the deceased alive on* 14 Sept, 1967, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Mary Louise Smith, M.D. 594 (Degree or title)

23b. ADDRESS Box 390 Blackfoot, Idaho

23c. DATE SIGNED 14 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-18-67

24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery

24d. LOCATION (City, town, or county) (State) Mountain Home, Elmore, Idaho

DATE REC'D BY LOCAL REG. Sept 20, 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Howard Packham

LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3889
Local Reg. No. 112
Reg. Dist. No. 600

BIRTH NO.

SEP 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061 204
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 4Mo20Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 023

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) Sky View Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Allen	Allen	Jewett	Sept. 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Widower 2	13 Dec 1898	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming		U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Jewett			

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. Informant's Signature and Address
No	518-36-6780	H. Hansen, Ln State Hosp. South ADDRESS Blackfoot

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS (1) Fractured hips, right with open reduction (2) Post-op pneumonitis — Aug '67
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11 Sept, 1967, *to* 14 Sept, 1967, *that I last saw the deceased alive on* 14 Sept, 1967, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Mary Louise Smith MD	Box 390 Blackfoot, Idaho	14 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 19, 67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 19, 1967	Dorothy L. Jones	L. Dean Hill	E-466

FIRM NAME: Twin Falls Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 16 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3890
Local Reg. No. 120
Reg. Dist. No. 600

BIRTH NO.

RECEIVED OCT 4 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
c. LENGTH OF STAY (in this place): 3 yrs. 10 3
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rich Lane (Route #3) 007

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 061
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
d. STREET ADDRESS (If rural, give location): Rich Lane (Rt. #3)

3. NAME OF DECEASED (Type or Print): a. (First) Florence b. (Middle) Louise c. (Last) Woodland

4. DATE OF DEATH: (Month) Sept. (Day) 14, (Year) 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Sept. 15, 1896

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months 11 Days 29
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Richmond, Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Lee Rollison — BIRTHPLACE: Roxberry, Virginia

14. MOTHER'S MAIDEN NAME: Nannie Baker Hall — BIRTHPLACE: Hanover County, Va.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-20-5145B

17. INFORMANT'S OWN SIGNATURE: Leo M. Woodland — ADDRESS: Rt. #3 Blackfoot

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1762

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Liver Disease Metastatic — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Carcinoma of the Spine — 4 years.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-6, 1967, *to* 8-24, 1967, *that I last saw the deceased alive on* 8-24, 1967, *and that death occurred at* 11:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: O. Dean Packer 403 — (Degree or title): M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: 9-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-18-67

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.: Sept 22, 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Howard Packham — LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3891
Local Reg. No. 106
Reg. Dist. No. 600

RECEIVED

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
SEP 25 1967
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
LENGTH OF STAY (in this place): 24 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 061
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 320 S.E. Main

3. NAME OF DECEASED (Type or Print): a. (First) MARY b. (Middle) c. (Last) HARMEL

4. DATE OF DEATH (Month) (Day) (Year): September 14, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: June 25, 1886

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Russia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE
ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Myocardial Infarction
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 2 Prof Myocardial Infarction

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 20, 1967, *to* Sept 14, 1967, *that I last saw the deceased alive on* Sept 14, 1967, *and that death occurred at* 9 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: Sept 15, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: Sept 14, 67

24c. NAME OF CEMETERY OR CREMATORY: Lemmon cemetery

24d. LOCATION (City, town, or county) (State): Lemmon, So. Dakota

DATE REC'D BY LOCAL REG.: Sept. 15, 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Dean Hill
LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED.
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Oct 16, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3892
Local Reg. No. 114
Reg. Dist. No. 500

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bingham 061 207
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 7mo 14 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 10
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): 1275 Sage

3. NAME OF DECEASED (Type or Print): a. (First) Buck; b. (Middle) L.; c. (Last) Allen

4. DATE OF DEATH (Month) (Day) (Year): September 15, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 31, 1904

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Rancher

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David Allen
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Pearl Jensen
BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-30-8359

17. INFORMANT'S OWN SIGNATURE: Med. Records-State Hospital South, Mary Payne
ADDRESS

18. CAUSE OF DEATH 4300

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subacute bacterial endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (c) Arteriosclerotic heart disease with aortic valve disease — years
DUE TO (c) (b) Alpha streptococcus infection — June 1, 1967

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. CBS assoc. c senile brain disease — 1½ yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 4, 19 67, *to* Sept 15, 19 67, *that I last saw the deceased alive on* Sept 15, 19 67, *and that death occurred at* 12 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Mary Louise Smith, M.D. 594

23b. ADDRESS: State Hospital South, Blackfoot

23c. DATE SIGNED: 20 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-19-67

24c. NAME OF CEMETERY OR CREMATORY: Grover City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.: Sept 20, 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Howard Packham
LICENSE NO.: E 338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
OCT 10 1967
Bureau of Vital Statistics

State of Idaho
County of Bannock } ss.

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)

for Buck L. Allen (Name on Original Certificate) who died (Was Born or Died) on Sept 15, 1967 (Date of Event)

in Blackfoot, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by Marriage Certificate (Bible Record, Insurance Policy, Etc.) prepared on Aug. 29 - 1928 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#7	Never Married	Married

Subscribed and sworn to before me this 9th day of October 1967

Notary Public, residing at Idaho Falls Idaho

My commission expires 3-15-69

(Seal)

Signed Mrs Ethel W Allen
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

1275 Sage, Idaho Falls Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Bannock } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 9 day of October 1967

Notary Public, residing at Idaho Falls Idaho

My commission expires 3-15-69

(Seal)

Signed Verda W Wilson
(Signature of Any Credible Person)

Jackson Wyoming Box 62
(Street Address, City, State)

FORM DH 60-155

L. 10-6-67

photocopy of marriage certificate for LeRoy B. Allen and Melvina E. Giles were married Aug 29, 1928, State of Wyoming. viewed by VS

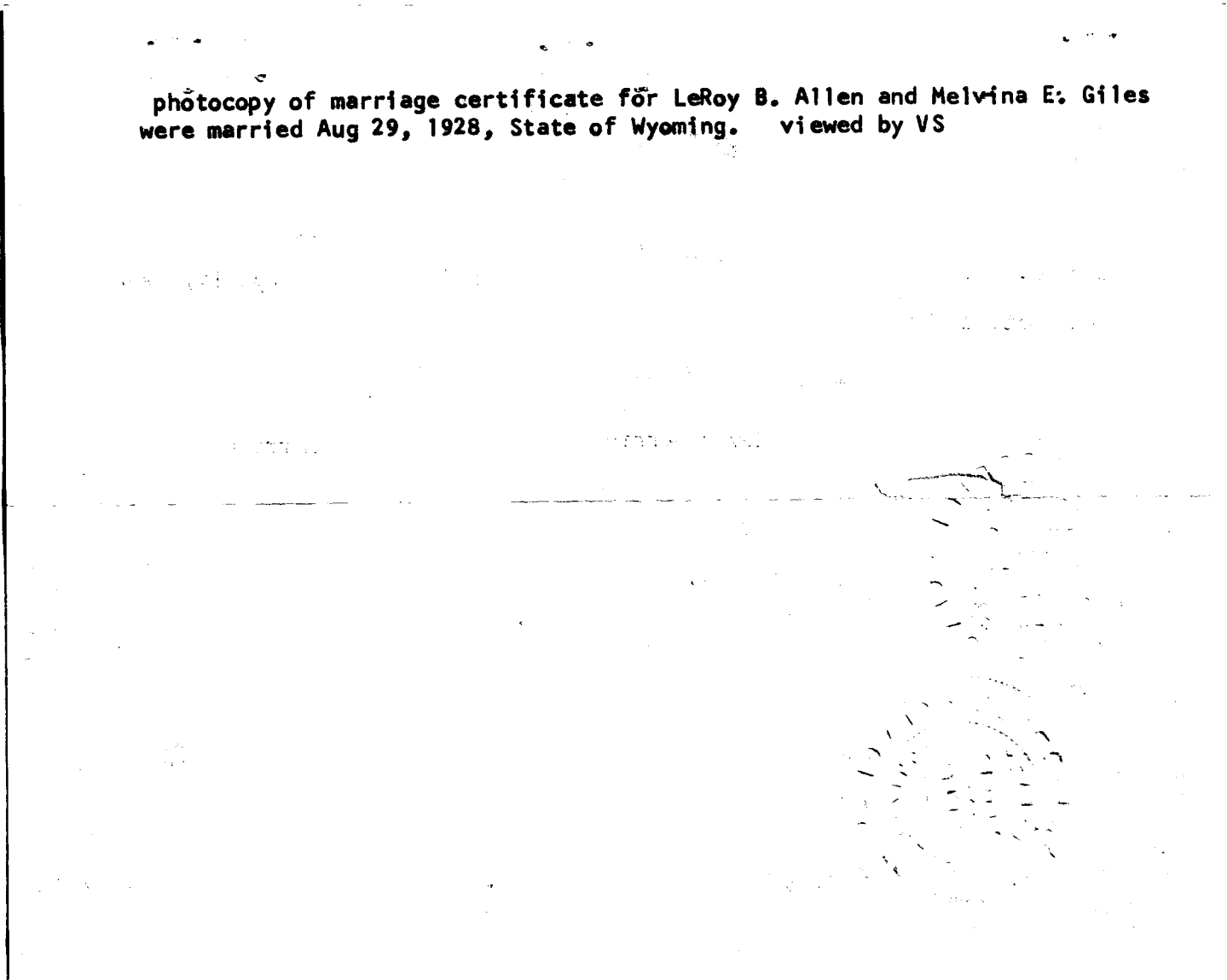

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 114
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH — SEP 25 1967

a. COUNTY: Bingham

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot

c. LENGTH OF STAY (in this place): 7mo14days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bonneville

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho

d. STREET ADDRESS (If rural, give location): 1275 Sage

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
BUCK	L.	ALLEN	September 15 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	July 31 1904	63		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Rancher	Rancher	Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Allen	Utah	Pearl Jensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 30 8359	Mary Payne	Med. Records-State Hospital South

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subacute bacterial endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 5 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic heart disease with aortic valve disease ← — 10 years

DUE TO (c) alpha Streptococcus infection ← June 1 1967

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. CBS assoc. & senile brain disease — 1½ yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4 February *19* 67, *to* 15 Sept., *19* 67, *that I last saw the deceased alive on* 15 Sept., *19* 67 *and that death occurred at* 12:08 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Mary Louise Smith MD	State Hospital South Blackfoot Ida.	20 Sept. '67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/19/67	Grace City Cemetery	Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 20, 1967	Dorothy Jo Jones	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 - inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 23 1997

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3893
Local Reg. No. 119
Reg. Dist. No. 600

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN: Blackfoot
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN: Blackfoot
d. STREET ADDRESS (If rural, give location): 433 N. Oak

3. NAME OF DECEASED (Type or Print): a. (First) Henry b. (Middle) Simpson c. (Last) Burt

4. DATE OF DEATH: (Month) Sept. (Day) 21, (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: June 10, 1882

9. AGE (In years last birthday): 85 | IF UNDER 1 YEAR: Months 3, Days 11 | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Butcher 21

10b. KIND OF BUSINESS OR INDUSTRY: Meat Market

11. BIRTHPLACE (State or foreign country): Clarkston, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John W. Burt — BIRTHPLACE: Lachgelly, Scotland

14. MOTHER'S MAIDEN NAME: Margaret Simpson — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-09-0191

17. INFORMANT'S OWN SIGNATURE: Henry L Burt — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremic Poisoning

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cardiac Decompensation

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

4344

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1964 *to* Sept, 1967, *that I last saw the deceased alive on* Sept 21, 1967 *and that death occurred at* 7:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: 9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-25-67

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.: Sept 25, 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Howard Packham

LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3894
Local Reg. No. 117
Reg. Dist. No. 601

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Shelley
c. LENGTH OF STAY IN (Hospital or Institution) (Or in this place) -0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) USHighway #15, north of Shelley

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 05 California SSS
b. COUNTY Humboldt
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harris
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS b. (Middle) EDGAR 000 c. (Last) JONES

4. DATE OF DEATH (Month) (Day) (Year) September 23 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 3

8. DATE OF BIRTH October 6, 1945

9. AGE (In years last birthday) 21 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Communications tech 05

10b. KIND OF BUSINESS OR INDUSTRY U.S.Navy

11. BIRTHPLACE (State or foreign country) Portland, Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edgar Addison Jones

BIRTHPLACE No record

14. MOTHER'S MAIDEN NAME Aileen Marie Osborne

BIRTHPLACE No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) In service (If yes, give war or dates of service) present 8

16. SOCIAL SECURITY NO. 547-62-8855

17. INFORMANT'S OWN SIGNATURE M. T. Clark ADDRESS U.S.Navy Records, by M. T. CLARK, LT USN

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Lumbar Spine severed — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Spinal cord

DUE TO (c) Auto accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 06

21c. (CITY, TOWN, OR TOWNSHIP) 12 15 Mi/Hy N.I.S. 15 Blackfoot 061 (COUNTY) Bingham (STATE) Idaho

21d. TIME OF INJURY (Month) 9 (Day) 23 (Year) 67 (Hour) 4.30 P.M.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ~~accident~~, 19 ~~Sept~~, 19 ~~Sept~~, 19 ~~67~~, that I last saw the deceased alive on ~~Sept~~ 19 ~~67~~ and that death occurred at ~~4:30~~ P.M., from the causes and on the date stated above.

23a. SIGNATURE Carl Staley M.D. 583 (Degree or title) Coroner

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE Sept.26, 1967

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) Harris, Humboldt Co., California

DATE REC'D BY LOCAL REG. Sept 25 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER James A. Anderson LICENSE NO. E-387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Wm. Haley, Coroner

Certificate of Death

STATE OF IDAHO

State File No. 3895
Local Reg. No. 118
Reg. Dist. No. 600

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 061
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 194 North Spruce St.

3. NAME OF DECEASED (Type or Print): a. (First) SHIRLEY b. (Middle) RUTH 039 c. (Last) SMITH

4. DATE OF DEATH: (Month) (Day) (Year): September 23, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: November 26, 1909
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Custer, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walter Silver — BIRTHPLACE: Oklahoma
14. MOTHER'S MAIDEN NAME: Martha Mavrity — BIRTHPLACE: Challis, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-26-5093
17. INFORMANT'S OWN SIGNATURE: Maxine D. Smith — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

330X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA (Ruptured Berry Aneurysm) — INTERVAL BETWEEN ONSET AND DEATH: 23 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Diabetes Mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* September 23 19 67, *that I last saw the deceased alive on* September 23 19 67, *and that death occurred at* 10 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: A. E. Miller Jr 361 (Degree or title): M.D.
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Sept 25, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: September 26, 67
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Sept. 26, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: C. Dean Hill — LICENSE NO.: E-466
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3896
Local Reg. No. 116
Reg. Dist. No. 601

RECEIVED OCT 4 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
c. LENGTH OF STAY (in this place): minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Interstate Highway 15 (007)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) JALYN b. (Middle) c. (Last) SHARP

4. DATE OF DEATH (Month) (Day) (Year): September 24, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: September 20, 1965

9. AGE (In years last birthday): 2 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Darrell B. Sharp — BIRTHPLACE: Rexburg, Idaho

14. MOTHER'S MAIDEN NAME: Janice Wasden — BIRTHPLACE: Rexburg, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Earl Sharp — ADDRESS: Rexburg, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Crushed Skull — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Thrown from car + car rolled

DUE TO (c): over her crushing body

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): ½ mile north I.S. 15 Blackfoot Bingham Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* September 24 19 67, *to* ~~xxxxxxxxxxxx~~ *that I last saw the deceased alive on* ~~xxxxxxxxxxxx~~ 19 ~~xxx~~, *and that death occurred at* 2:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Earl Sharp 583 4 (Degree or title): coroner, Bingham county — **23b. ADDRESS**: Blackfoot, Idaho — **23c. DATE SIGNED**: Sept 25, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial — **24b. DATE**: September 27, 67 — **24c. NAME OF CEMETERY OR CREMATORY**: Rexburg cemetery — **24d. LOCATION** (City, town, or county) (State): Rexburg, Idaho

DATE REC'D BY LOCAL REG.: Sept 26, 1967 — REGISTRAR'S SIGNATURE: Dorothy J. Jones — **25. EMBALMER**: Coleman Hill — LICENSE NO.: E-466

FIRM NAME: for Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3897
Local Reg. No. 121
Reg. Dist. No. 600

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 100 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 456 Grant Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 061
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 456 Grant Street

3. NAME OF DECEASED (Type or Print)
a. (First): Clara
b. (Middle):
c. (Last): Heindel

4. DATE OF DEATH (Month) (Day) (Year): September 26 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: October 29, 1900
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Clark — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Sarah Ann Thomas — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Lester P. Heindel — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Gall bladder disease — several years.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 26 Sept, 1967, *to* 26 Sept, 1967, *that I last saw the deceased alive on* See reverse, 19____, *and that death occurred at* 9:00 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Walter G. Hoge MD 234
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: 27 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/30/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 4, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Ralph M. Wood — LICENSE NO.: 413

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 15 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician: Patient was expired before I saw her & I have never seen her before professionally.

State File No. 3898
Local Reg. No. 42
Reg. Dist. No. 410

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 14 1967 070

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Reservoir 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 529 7th. Ave. West

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle)
c. (Last) VOS

4. DATE OF DEATH (Month) (Day) (Year) Sept. 5, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 19, 1895
9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Isquat, Holland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Arend Vos — BIRTHPLACE Holland
14. MOTHER'S MAIDEN NAME Hilje Elema — BIRTHPLACE Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W. W. I 3
16. SOCIAL SECURITY NO. 543 26 5218
17. INFORMANT'S OWN SIGNATURE X Mrs Katie Beem — ADDRESS Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7954

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Presumed natural causes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) (found in Magic Reservoir — Cause of death not determined)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Unknown — presume immediate

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* approx 2 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Scott Earl Mo 583 Coroner 4
23b. ADDRESS Sun Valley, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY Wendell Cemetery
24d. LOCATION (City, town, or county) (State) Wendell, Idaho

DATE REC'D BY LOCAL REG. Sept 12/67
REGISTRAR'S SIGNATURE Robert H. Wright per C.B.W.
25. EMBALMER W. L. Hove
LICENSE NO. E-431
FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3899
Local Reg. No. 43
Reg. Dist. No. 410

BIRTH NO.

RECEIVED SEP 18 1967 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN: Sun Valley
b. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 070
b. COUNTY: Blaine
c. CITY OR TOWN: Ketchum
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Shirley		Bell	Sept. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Oct. 24, 1926	40				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife O	Home	No. Platt Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John R. Mulick	Nebraska	Florence Foley	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Shirley Bell	Ketchum Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolus 633X — INTERVAL BETWEEN ONSET AND DEATH: unknown — probably few hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) (Sequela of elective hysterectomy)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* August, 1967, *to* 10 Sept, 1967, *that I last saw the deceased alive on* 10 Sept, 1967, *and that death occurred at* 4:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert Wright 151	MD	Sun Valley Idaho	9/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 13, 67	Ketchum Cemetery	Ketchum Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 16-'67	Robert H. Wright	Ruth Bird	E-373

FIRM NAME: Bird Funeral Home, Hailey, Idaho.

Federal Security Agency
United States Public Health Service

Form DH-6302 (Rev. 6-63, W.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3900
Local Reg. No. 44
Reg. Dist. No. 410

RECEIVED OCT 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gannett Rural
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 070
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gannett
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Nona	Irene	Bair	Sept. 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed	4-18-1879	89		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	Home	Bertram, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John W. Robinson	Iowa	Mary Harman	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Np	None	Mrs. Wm A. Price	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Senility & generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 19 67, *to* death, 19___, *that I last saw the deceased alive on* April, 19 67, *and that death occurred at* 4 12 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R Scott Eaton 583 MD (Coroner)	Sun Valley, Idaho Blaine County	9/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) / (State)
Removal 3	Sept. 29, 67	Memorial Park	Clenton Iowa

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 9-1967	Robert H. Wright	Burt Bird	E 373

FIRM NAME: Bird Funeral Home Hailey, Id

Federal Security Agency
United States Public Health Service

Form DH-6302 (Rev. 6-57)

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 23 1995

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED--CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3901
Local Reg. No. 4291
Reg. Dist. No. 410

BIRTH NO.

RECEIVED STATE OF IDAHO

OCT 20 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Carey
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 070
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Carey
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Oliver	Otto	Eldredge	Sept. 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Jan. 1, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29		Carey, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Forest H. Eldredge,	Utah	Ruth Haward	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3 8224	519-16-3436	Robert Eldredge	912 W. Jenny Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Canine-cerebral trauma — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT ✓ SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
	Carey 1st street	13 Carey, Blaine Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Sept 30 '67 1:30 p.m.		Jeep over turned

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Scott Earle MD 583 Coroner 4	Sun Valley, Idaho	10/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 3, 1967	Carey Cemetery	Carey Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 16/67	Robert H. Wright	Keith Bird Keith Bird	E 373

FIRM NAME: Bird Funeral Home Hailey Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev 6-63 W

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3902
Local Reg. No. 105
Reg. Dist. No. 110

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 09 1 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 27 Montana
b. COUNTY: 555 S anders
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Noxon
d. STREET ADDRESS (If rural, give location): Box 544

3. NAME OF DECEASED (Type or Print): a. (First) Wesley b. (Middle) W. c. (Last) Giffin

4. DATE OF DEATH (Month) (Day) (Year): Sept. 2, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 5
8. DATE OF BIRTH: May 10, 1906
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Own ranch
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Giffin — BIRTHPLACE: U.S.A.
14. MOTHER'S MAIDEN NAME: Minnie Geddes — BIRTHPLACE: U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: [illegible]
17. INFORMANT'S OWN SIGNATURE: X Ruth E Giffin — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Artero sclerotic heart dis — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-6, 1962 *to* 9-2-, 1967 *that I last saw the deceased alive on* 9-2, 1967, *and that death occurred at* 10:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] 327 MD (Degree or title)
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): ~~Burial~~ Removal
24b. DATE: Sept. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Noxon Cemetery
24d. LOCATION (City, town, or county) (State): Noxon, Montana

DATE REC'D BY LOCAL REG.: Sept. 8, 1967
REGISTRAR'S SIGNATURE: Phyllis G Gilbertson
25. EMBALMER: L. C. Moon, Jr.
LICENSE NO.: E-405
FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

APR 6 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3903
Local Reg. No. 111
Reg. Dist. No. 110

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 09 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Yusten Rest Home 324 S. Boyer 041

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 090 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - (Sunnyside)
d. STREET ADDRESS (If rural, give location): Rt. 1, Sandpoint

3. NAME OF DECEASED (Type or Print)
a. (First): Raymond
b. (Middle): Arnold
c. (Last): Pepper

4. DATE OF DEATH (Month) (Day) (Year): Sept. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 7, 1909
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self-employed 24
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Colorado Springs, Colorado
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ray E. Pepper — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Grace McComb — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: 552-20-7195
17. INFORMANT'S OWN SIGNATURE: G. Mary Pepper — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 180X Meta static carcinoma to the lungs — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) primary carcinoma of kidney — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-8, 1967, *to* 9-10, 1967, *that I last saw the deceased alive on* 9-8, 1967, *and that death occurred at* 11:05P *m., from the causes and on the date stated above.*

23a. SIGNATURE: B. Marienau 327 (Degree or title) MD
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 9-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county): Sandpoint (State): Idaho

DATE REC'D BY LOCAL REG.: Sept. 28, 1967
REGISTRAR'S SIGNATURE: Phyllis Y. Pilchetta
25. EMBALMER: L. G. Moon, Jr. — LICENSE NO.: E-405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 3 1967

SEP 25 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3904
Local Reg. No. 106
Reg. Dist. No. 110

BIRTH NO.

RECEIVED SEP 18 1967 Vital Statistics Bureau of Health

1. PLACE OF DEATH
a. COUNTY: Bonner 09
b. CITY OR TOWN: Sandpoint
LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 09
b. COUNTY: Bonner
c. CITY OR TOWN: Sandpoint
d. STREET ADDRESS (If rural, give location): 516 St. Clair

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Kenneth	Alfred	Nelson	Sept. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 5	Feb. 7, 1905	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Forest Service 08	U.S. Government	Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nels Nelson	Wisconsin	Carrie Sliter	North Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	—	519-01-5717	x Nancy E Nelson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	2001 Lymphosarcoma	1 yr.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-64, 1967, *to* Sept, 19 67, *that I last saw the deceased alive on* Sept 10, 19 67, *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Sandpoint Ida	9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 13, 1967	Pinecrest Cemetery	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 13, 1967	[signature]	L. G. Moon, Jr.	E-405

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3905
Local Reg. No. 107
Reg. Dist. No. 110

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 09
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 715 Church Street

3. NAME OF DECEASED (Type or Print): a. (First) Melvin b. (Middle) Newton c. (Last) Buckmaster

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 11, 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 19, 1918
9. AGE (In years last birthday): 49
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): South Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Arthur J. Buckmaster — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Mary Jane Black — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II 42
16. SOCIAL SECURITY NO.: 518-14-6589
17. INFORMANT'S OWN SIGNATURE: Mrs Melvin Buckmaster — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3223

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Hypo Glycemia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fatty degeneration of liver — years
DUE TO (c) Alcoholism — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title) MD
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 9-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Lakeview Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Sept. 15, 1967
REGISTRAR'S SIGNATURE: Phyllis Y. Willette
25. EMBALMER: L. G. Moon, Jr. — LICENSE NO.: E-405
FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 11 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 10 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3906
Local Reg. No. 110
Reg. Dist. No. 110

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics 323

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 23 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 090
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clark Fork
d. STREET ADDRESS (If rural, give location): —

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): Anthony
c. (Last): Foster

4. DATE OF DEATH (Month) (Day) (Year): September 14, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 2, 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Clark Fork, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joe Foster — BIRTHPLACE: Czechoslovakia
14. MOTHER'S MAIDEN NAME: Tresa Forester — BIRTHPLACE: Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-20-0332A
17. INFORMANT'S OWN SIGNATURE: Ethel G. Foster — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5271

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PNEUMONIA Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Congestive Heart Failure — 2 months
DUE TO (c) Senior enzymes — years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 23, 1967, *to* Sept 14, 1967, *that I last saw the deceased alive on* Sept 13, 1967, *and that death occurred at* 6:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Frank [illegible] 471 (Degree or title)
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 9/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county): Sandpoint (State): Idaho

DATE REC'D BY LOCAL REG.: Sept. 25, 1967
REGISTRAR'S SIGNATURE: Fayellis Y. Tibbetts
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 22 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3907
Local Reg. No. 109
Reg. Dist. No. 110

BIRTH NO.

RECEIVED OCT 2 1967 Vital Statistics Bureau

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bonner 09

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint

c. LENGTH OF STAY (in this place): 5 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 09

b. COUNTY: Bonner

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint

d. STREET ADDRESS (If rural, give location): 215 Pine Street

3. NAME OF DECEASED (Type or Print)

a. (First): Rose

b. (Middle): Emma

c. (Last): Buchert

4. DATE OF DEATH (Month) (Day) (Year): Sept. 17, 1967

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Dec. 7, 1890

9. AGE (In years last birthday): 76

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): South Dakota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael Filion

BIRTHPLACE: New York

14. MOTHER'S MAIDEN NAME: Alice Drey

BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 532-32-4430 A

17. INFORMANT'S OWN SIGNATURE: Loren Cunningham

ADDRESS:

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4341

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): PNEUMONIA - Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 2 week

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): UREMIA — 3½ month

DUE TO (c): Congestive Heart Failure — progressive for years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/25, 1967, *to* Sept 17 1967, *that I last saw the deceased alive on* Sept 15, 1967, *and that death occurred at* 11 00 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] D

23b. ADDRESS: Spokane Idaho

23c. DATE SIGNED: 9/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 20, 1967

24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: Sept. 25, 1967

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Dale G. Coffelt

LICENSE NO.: E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 16 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3908
Local Reg. No. 112
Reg. Dist. No. 110

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 09 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 09
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 314 N. 6th Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Harry b. (Middle) LaVerne c. (Last) Lee

4. DATE OF DEATH: (Month) Sept. (Day) 26, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 21, 1902

9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Road Maintenance 08

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Forest Service

11. BIRTHPLACE (State or foreign country): Montana

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: No record
BIRTHPLACE: No record

14. MOTHER'S MAIDEN NAME: Eva Riddle
BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 518-05-0071

17. INFORMANT'S OWN SIGNATURE: Mrs Harry Lee
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Severe Emphysema and — 8 years

DUE TO (c) Chronic Lung Disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 21, 1955, *to* Sept 26, 1967, *that I last saw the deceased alive on* Sept 26, 1967, *and that death occurred at* 2:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS

23c. DATE SIGNED: 9/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 29, 1967

24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Oct. 2, 1967

REGISTRAR'S SIGNATURE: Phyllis G. Willette

25. EMBALMER: Dale G. Coffelt

LICENSE NO.: E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service

Form PH-63021

OCT 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 12 1985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3909
Local Reg. No. 114
Reg. Dist. No. 110

RECEIVED
OCT 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091 313
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 090
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sagle
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Fred
b. (Middle): Hilton
c. (Last): Hanneman

4. DATE OF DEATH (Month) (Day) (Year): Sept. 26, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov. 1, 1896
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Own farm
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fredrick Hanneman — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Abbie Loney Molitor — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 518-34-5253
17. INFORMANT'S OWN SIGNATURE: Mrs. Floral T. Hanneman — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 578X upper gastro-intestinal bleeding — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 16, 1967, *to* Sept 26, 1967, *that I last saw the deceased alive on* 9-26, 1967, *and that death occurred at* 3:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Fred E Mancinau 327 MD
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Oct. 5, 1967
REGISTRAR'S SIGNATURE: Phyllis G. Tibbetts
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3910
Local Reg. No. 113
Reg. Dist. No. 110

Certificate of Death

RECEIVED
OCT 16 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091 315
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 15 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 090
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clark Fork
d. STREET ADDRESS (If rural, give location): Within village limits

3. NAME OF DECEASED (Type or Print)
a. (First): Albert
b. (Middle): Oswald
c. (Last): Nowlin

4. DATE OF DEATH (Month) (Day) (Year): Sept. 27, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 29, 1885
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber 17
10b. KIND OF BUSINESS OR INDUSTRY: Own Sawmill
11. BIRTHPLACE (State or foreign country): Michigan
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Orville Nowlin — BIRTHPLACE: Michigan
14. MOTHER'S MAIDEN NAME: Helen Erway — BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 518-22-9934
17. INFORMANT'S OWN SIGNATURE: James W Nowlin — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Congestive + left Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Renal failure & Uremia — 2 mos
DUE TO (c): Ca of Prostate & metastases — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~Aug~~ Aug, 1967, *to* Sept 27, 1967, *that I last saw the deceased alive on* 9-27, 1967, *and that death occurred at* 9:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Charles G Smith MD
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 10/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify): ~~Burial~~ Removal
24b. DATE: Oct. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Choteau Cemetery
24d. LOCATION (City, town, or county) (State): Choteau, Montana

DATE REC'D BY LOCAL REG.: Oct. 4, 1967
REGISTRAR'S SIGNATURE: Phyllis G. Tibbetts
25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

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MAR 21 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3911
Local Reg. No. 115
Reg. Dist. No. 110

RECEIVED OCT 16 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bonner 09 201

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint

LENGTH OF STAY (in this place): 1 month

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 090

b. COUNTY: Bonner

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sagle

d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Albert; b. (Middle) Cecil; c. (Last) Sinclair

4. DATE OF DEATH (Month) (Day) (Year): Sept. 27, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Feb. 4, 1909

9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Colorado

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Sinclair — BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Catherine Frantz — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 524-05-0199

17. INFORMANT'S OWN SIGNATURE: Carl G. Frantz — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): severe emphysema — 10 years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: renal failure — 10 days

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY: YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1967, *to* Sept 27, 1967, *that I last saw the deceased alive on* Sept. 26, 1967, *and that death occurred at* 1:45A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Fred E. Mauermann MD

23b. ADDRESS: Sandpoint Idaho

23c. DATE SIGNED: 10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: Sept. 29, 1967

24c. NAME OF CEMETERY OR CREMATORY: Moon Crematory

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Oct. 5, 1967

REGISTRAR'S SIGNATURE: Phyllis G. Tibbetts

25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service

Form PH-63021

DUTIES:

OCT 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3912
Local Reg. No. 117
Reg. Dist. No. 110

BIRTH NO.

OCT 24 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 091 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 090
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sagle
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Noel
c. (Last): Hawkins

4. DATE OF DEATH (Month) (Day) (Year): Sept. 30, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 11, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Washington Hawkins — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Ella Weber — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 518-05-6799
17. INFORMANT'S OWN SIGNATURE: Ralph Hawkins — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5020

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 1-2 dy
Pneumonia — 1 wk

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Emphysema severe — 5-6 years
DUE TO (c): Chronic Bronchitis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Cancinoma of prostate — 11 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 15, 1956, *to* Sept 30, 1967, *that I last saw the deceased alive on* Sept 30, 1967, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 471 MD
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 10/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Oct. 16, 1967
REGISTRAR'S SIGNATURE: Phyllis G. Tibbetts
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

OCT 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 25 1967 Bureau of Vital Statistics

State File No. 3913
Local Reg. No. 234
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 526 L St.

3. NAME OF DECEASED (Type or Print): a. (First) Mrs. b. (Middle) Clara Elisa c. (Last) Fiksted Wadsworth

4. DATE OF DEATH: (Month) Aug (Day) 20, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed	July 25, 1884	83	0	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Carl Nilsen Haugsten — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Elizabeth Jonason Flod — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Lucille F. Garner — ADDRESS: Brigham City Ut.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — years
DUE TO (c) also Senility —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1964 *to* Aug 20, 1967, *that I last saw the deceased alive on* Aug 21, 1967, *and that death occurred at* 8:00 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Frank H Natch MD	Idaho Falls Idaho	6 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem & Bur	Aug 24, 1967	Rexburg City Cemetery	Rexburg, Idaho

DATE REC'D BY LOCAL REG.: Sept 5-1967
REGISTRAR'S SIGNATURE: Emma Bridges
25. EMBALMER: Leo A. Williams — LICENSE NO.: E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended December 5, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3914
Local Reg. No. 265
Reg. Dist. No. 610

BIRTH NO:

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 841 Crestmont Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Margaret; b. (Middle); c. (Last) Taylor

4. DATE OF DEATH: (Month) August (Day) 23, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Sept 30, 1901

9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telegrapher

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Anaconda, Montana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Karas
BIRTHPLACE: Austria

14. MOTHER'S MAIDEN NAME: Susie Ondrecyk
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 712-05-6127

17. INFORMANT'S OWN SIGNATURE: Ray D. Taylor
ADDRESS: Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on* August 23, 19 67, *and that death occurred at* 10:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton T. Rees, M.D.

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: 9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 8-26-67

24c. NAME OF CEMETERY OR CREMATORY: Anaconda Cemetery

24d. LOCATION (City, town, or county) (State): Anaconda, Montana

DATE REC'D BY LOCAL REG.: Sept 12, 1967

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
DEC 1 1967
Bureau of Vital Statistics

State of Idaho } ss.
County of Bonneville }

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Margaret Taylor (Name on Original Certificate) who Died (Was Born or Died) on 8/23/67 (Date of Event)
in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Life's Work (Bible Record, Insurance Policy, Etc.) prepared on _____ (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Usual occupation	Housewife	Telegrapher
Kind of Business	own Home	Rail Road.
Social Security #	Unknown	712-05-6127

Subscribed and sworn to before me this 1st day of December, 1967

Ralph M. Hood
Notary Public, residing at Idaho Falls, Idaho
My commission expires 11/20/70
(Seal)

Signed Jack a Wood Jr
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)
223 No Ridge Ave Idaho Falls, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Bonneville }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 1st day of December, 1967

Ralph M. Hood
Notary Public, residing at Idaho Falls, Idaho
My commission expires 11/20/67
(Seal)

Signed Jack a Wood
(Signature of Any Credible Person)
223 No Ridge Ave Idaho Falls, Idaho
(Street Address, City, State)

FORM DH 60-155

RALPH L. WOOD
NOTARY
PUBLIC
STATE OF IDAHO

RALPH L. WOOD
NOTARY
PUBLIC
STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3914
Local Reg. No. 263
Reg. Dist. No. 610

BIRTH NO.

SEP 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): DOD
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 841 Crestmont Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Margaret; b. (Middle); c. (Last) Taylor

4. DATE OF DEATH: (Month) August (Day) 23 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	September 30, 1901	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Anaconda, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Karas	Austria	Susie Ondrecyk	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Unknown	Ray D Taylor	Idaho Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* August 23, 19 67, *and that death occurred at* 10-30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Milton T. Reese M.D.	Idaho Falls, Ida	9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	8/26/67	Anaconda Cemetery	Anaconda Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 12-67	Emma Rudges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 5 _ 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3915
Local Reg. No. 266
Reg. Dist. No. 610

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 SEP 25 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (If not in hospital or institution, give street address or location): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 221
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony Rural
d. STREET ADDRESS (If rural, give location): RFD#2

3. NAME OF DECEASED (Type or Print)
a. (First): JOSIE
b. (Middle):
c. (Last): MOON

4. DATE OF DEATH (Month) (Day) (Year): August 26, 1967

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: April 22, 1899
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): St. Anthony #2 (Egin) Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Levi Moon — BIRTHPLACE: Holden, Utah
14. MOTHER'S MAIDEN NAME: Dora Prothero — BIRTHPLACE: Alta, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-42-8285-A
17. INFORMANT'S OWN SIGNATURE: Frank Moon — ADDRESS: St. Anthony Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Breast with
ANTECEDENT CAUSES — DUE TO (b): Melastom Bone & Lung
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

19a. DATE OF OPERATION: 1964
19b. MAJOR FINDINGS OF OPERATION: Carcinoma Breast Advanced Class III
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 28, 1964, *to* August 26, 1967, *that I last saw the deceased alive on* August 26, 1967, *and that death occurred at* 6:58P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. W. Corbett, M.D. 104
23b. ADDRESS: 798 South Blvd. Idaho Falls, Idaho
23c. DATE SIGNED: Sept. , 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 30 August 67
24c. NAME OF CEMETERY OR CREMATORY: Parker Cemetery
24d. LOCATION (City, town, or county) (State): Parker, Fremont, Idaho

DATE REC'D BY LOCAL REG.: Sept 11-67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: M. L. Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 4 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Hal Davis

Certificate of Death

STATE OF IDAHO

State File No. 3916
Local Reg. No. 267
Reg. Dist. No. 610

BIRTH NO.

RECEIVED SEP 25 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
DURATION OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) L.D.S. Nursing Home.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lydia	Adeline	Thueson	Aug 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	23 Dec. 1877	89	8	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		Parowan, Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Freeman Webb	Utah	Alice Lemons	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			X Thomas Thueson	(Son)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4221 Autopsy not performed — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic CVD

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hal Davis 134	MD	Idaho Falls Ida	9.14.67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	2 Sept 1967	Fielding Mrmorial Park	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 28-67	Irma Rudgen	Leo A Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3917
Local Reg. No. 244
Reg. Dist. No. 610

RECEIVED SEP 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
STAY (in this place): OOO
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1185 Curtis Ave. OOO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): 1185 Curtis

3. NAME OF DECEASED (Type or Print): a. (First) Helen; b. (Middle) Elizabeth; c. (Last) Farrer

4. DATE OF DEATH: (Month) Sept. (Day) 1, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: Cauc

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed D

8. DATE OF BIRTH: Sept. 5, 1887

9. AGE (In years last birthday): 79 Yrs. | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (State or foreign country): Minneapolis, Minnesota

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: John Russell
BIRTHPLACE: Wisconsin

14. MOTHER'S MAIDEN NAME: Anna Ready
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-54-0227

17. INFORMANT'S OWN SIGNATURE: James W. Farrer
ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-10, 1967, *to* 9-1, 1967, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* —— *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 546 MD 1

23b. ADDRESS: Idaho Falls Ida

23c. DATE SIGNED: 9/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 5, 1967

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest

24d. LOCATION (City, town, or county) (State): Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG.: Sept. 18-1967

REGISTRAR'S SIGNATURE: Anna Rudgen

25. EMBALMER: L.M. Nalder Lloyd M Nalder

LICENSE NO.: E 275

FIRM NAME: Nalder Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3918
Local Reg. No. 285
Reg. Dist. No. 610

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 19 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1445 Halsey Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idahon 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1271 Albany Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
VERA	YVONNE	BROWN	September 2 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never married	August 20, 1947	20				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Public Schools
11. BIRTHPLACE (State or foreign country): Rigby, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Antone J. Brown — BIRTHPLACE: Howe, Idaho
14. MOTHER'S MAIDEN NAME: Geneva M. Turner — BIRTHPLACE: Bedford, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-56-4401
17. INFORMANT'S OWN SIGNATURE: Antone J. Brown — ADDRESS: Idaho Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HEMORRHAGE, INTRAPERITONEAL & RETROPERITONEAL — INTERVAL BETWEEN ONSET AND DEATH: 9767

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) PERFORATION OF LEFT EXTERNAL ILIAC ARTERY AND VEIN BY 22 CALIBER BULLET WOUND TO ABDOMEN
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
BLOOD ALCOHOL LEVEL - 2.16 MG/CC

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 2 SUICIDE
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 00
21c. (CITY, TOWN, OR TOWNSHIP) 101 IDAHO FALLS (COUNTY) BONNEVILLE (STATE) IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: HAZEL L. McGAFFEY, M.D. (Degree or title): CORONER 4
23b. ADDRESS: 2525 South Boulevard, Idaho Falls, Idaho
23c. DATE SIGNED: 9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 3-67
REGISTRAR'S SIGNATURE: Irma Burgess
25. EMBALMER: Orland L. Buck
LICENSE NO.: E-250

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

9/15/67

ADDITIONAL REMARKS by Physician: Because of circumstances of death, investigation are being continued thru F.B.I. Laboratory analysis of gun, Bullet + Clothing. Suicide Note was left however + handwriting. D/Med

Co. Sec's Copy

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3919
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 2 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton
d. STREET ADDRESS (If rural, give location): 225 3rd

3. NAME OF DECEASED (Type or Print): a. (First) Fredrick b. (Middle) Richard c. (Last) Chadwick

4. DATE OF DEATH: (Month) Sept. (Day) 2, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 29, 1883	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Park Valley, Utah	U.S.A.

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
Abraham Chadwick - St. Louis, Mo.	Olive Ann Cazier - Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE — ADDRESS
no		Alice Chadwick, Hazelton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia - — INTERVAL BETWEEN ONSET AND DEATH: week*

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis generalized — unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug. 16, 19 67, *to* Sept. 2, 19 67, *that I last saw the deceased alive on* Sept. 2, 19 67, *and that death occurred at* 4:00P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
294 L. K. Krantz, M.D.	798 South Blvd. Idaho Falls, Idaho	Sept. , 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	9/6/67	Pleasant View Cemetery	Burley, Cassia, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Anna Bridges	Retta L. Payne	6,358

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3920
Local Reg. No. 286
Reg. Dist. No. 610

RECEIVED OCT 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 48 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 340 Broadway

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 340 Broadway

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ROY	ROBERTS	RATHJEN	September 5 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	October 21, 1918	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	General	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hans Henry Rathjen	Germany	Anna Katherina Burmahl	Holland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-10-2213	Hazel L. McGaffey	Salmon, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PULMONARY EMBOLUS, SADDLE — INTERVAL BETWEEN ONSET AND DEATH: HOURS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) THROMBOSIS, FEMORAL VEIN
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ANASARCA, MASSIVE OBESITY, MARKED

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
NONE		IDAHO FALLS	BONNEVILLE	IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Type or Title)	23b. ADDRESS	23c. DATE SIGNED
Hazel L. McGaffey, M.D. CORONER	2525 South Boulevard, Idaho Falls Idaho	9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Sept. 9, 1967	Rose Hill Cemetery	Idaho Falls	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 3-1967	Anna Budgen	Orland E. Buck	E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency, United States Public Health Service — Form DH-63021

DUTIES:

FEB 9 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3921
Local Reg. No. 227
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville SEP 25 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY IN THIS PLACE: 68
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

BUREAU OF VITAL STATISTICS

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
d. STREET ADDRESS (If rural, give location): 205 Tendoy Drive

3. NAME OF DECEASED (Type or Print): a. (First) JOSEPH b. (Middle) ENOCH c. (Last) ERICKSON

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Oct. 17, 1898

9. AGE (In years last birthday): 68
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Erickson. BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Sarah Walker BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 519-12-5842

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Dora M. Erickson, Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 30, 1967, *to* Sept. 5, 1967, *that I last saw the deceased alive on* Sept. 5, 1967, *and that death occurred at* 6:45 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE L. K. Krantz, (Degree or title) M. D.

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: Sept. , 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sep. 8, 1967

24c. NAME OF CEMETERY OR CREMATORY: Lewisville

24d. LOCATION (City, town, or county) (State): Lewisville, Jefferson, Ida.

DATE REC'D BY LOCAL REG.: Sept. 16-1967

REGISTRAR'S SIGNATURE: Anna Burgess

25. EMBALMER: Bruce A. Eckersell Bruce A. Eckersell

LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Bingham

Certificate of Death

STATE OF IDAHO

State File No. 3922
Local Reg. No. 282
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN: Idaho Falls
LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: L.D.S Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 061
b. COUNTY: Bingham
c. CITY OR TOWN: Blackfoot
d. STREET ADDRESS (If rural, give location): 264 North Spruce

3. NAME OF DECEASED (Type or Print): a. (First) LEO b. (Middle) c. (Last) McCULLOCH

4. DATE OF DEATH (Month) (Day) (Year): September 6, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: April 21, 1896

9. AGE (In years last birthday): 71
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 10

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Freedom, Wyoming

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry McCulloch BIRTHPLACE: Salt Lake City, Utah

14. MOTHER'S MAIDEN NAME: Alice Jane Lee BIRTHPLACE: Toole, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.: 519-22-0911

17. INFORMANT'S OWN SIGNATURE: Goldie McCulloch ADDRESS: Blackfoot, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4918 Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) Diabetes Mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Intestinal Obstruction - (post Operated)

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* Sept 6, 1967, *that I last saw the deceased alive on* Sept 6, 1967, *and that death occurred at* 5:05a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leonard J. Bingham M.D.
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: Sept 7, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Groveland cemetery
24d. LOCATION (City, town, or county) (State): Bingham county Idaho

DATE REC'D BY LOCAL REG.: Oct. 1-1967
REGISTRAR'S SIGNATURE: Anna Rudger

25. EMBALMER: C. Dean Hill
LICENSE NO.: E-466
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 10 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3923
Local Reg. No. 249
Reg. Dist. No. 610

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville — OCT 9 1967 — 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls — LENGTH OF STAY (In this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 840 E. Elva Street 602

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101 — b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 840 E. Elva Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
OLA	A	MEDDAUGH	September 6 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	March 1, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Livestock	Ferndale, New York	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mark Meddaugh	New York	Susan Carpenter	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Willard L. Hitchcock	Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dehydration — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchial stomatitis
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ineffective erythropoiesis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1965, 19___, *to* present, 19___, *that I last saw the deceased alive on* Sept 5, 1967, *and that death occurred at* 3:35 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
a Wm Buck 633	M. D.	Idaho Falls, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 7, 1967	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 3-1967	Emma Burgin	Orland C. Buck	E-250

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3924
Local Reg. No. 270
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1003 Canyon

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Joseph
c. (Last): Firkins

4. DATE OF DEATH (Month) (Day) (Year): Sept 6, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 12, 1898
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months 8, Days 24 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Rockland, Idaho
12. CITIZEN OF WHAT COUNTRY?: USQ.

13. FATHER'S NAME: William Henry Firkins — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Jane Smithers — BIRTHPLACE: England ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Hazel Ann Firkins — ADDRESS: Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Anoxia & Diabetes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Previous "strokes" (Taken care of by Dr. B.T. Weeks in last illness)
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION: 7/12/67
19b. MAJOR FINDINGS OF OPERATION: Benign Prostatic Hypertrophy
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/10, 1967, *to* 8/21, 1967, *that I last saw the deceased alive on* 8/21, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gordon W. Reynolds MD 1 — 436
23b. ADDRESS: 554-4th St.
23c. DATE SIGNED: 9/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9 Sept. 1967
24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Sept. 16-1967
REGISTRAR'S SIGNATURE: Anna Bradgen
25. EMBALMER: Leo A. Williams
LICENSE NO.: E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 22 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS ~~OF THIS ITEM.~~ ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3925
Local Reg. No. 278
Reg. Dist. No. 611

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Irwin
c. LENGTH OF STAY (in this place): 3 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 100
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Irwin
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Coral		Weeks	September 7 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	December 25, 1898	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Rigby, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Later — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Mary Ann Prophet — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Lee L Jones — ADDRESS: Irwin Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE TRACHEOBRONCHITIS (SECONDARY TO SMOKE INHALATION

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (BUTANE TANK EXPLOSION & HOME FIRE)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. PULMONARY EMPHYSEMA AND PLEURAL FIBROSIS, LEFT & BRONCHIECTASIS, WITH RT HEART DILATATION & HYPERTROPHY Chronic

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
ACCIDENT	HOME 01	IRWIN (RURAL) 13 BONNEVILLE 100 IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hazel L. McGaffey M.D. CORONER	2525 SOUTH BOULEVARD	9/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/11/67	Pioneer Cemetery	Rigby Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 20-1967	Anna Rudges	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician MRS WEEKS HAD APPARENTLY ESCAPED FROM THE BURNING HOME, AND HAD CARRIED SEVERAL ITEMS OUT OF THE HOUSE, BUT COLLAPSED AND DIED NEAR THE SCENE BEFORE OTHERS ARRIVED. SHE APPARENTLY HAD A CHRONIC LUNG DISABILITY AND RIGHT HEART STRAIN WHICH COMBINED WITH SMOKE INHALATION AND THE EXCITEMENT RESULTED IN DEATH. H.L.M.

Certificate of Death

STATE OF IDAHO

State File No. 3926
Local Reg. No. 264
Reg. Dist. No. 61

RECEIVED SEP 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Ririe
c. LENGTH OF STAY IN THIS PLACE: 3 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway # 26, 9 miles East Ririe

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah
b. COUNTY: Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salt Lake City
d. STREET ADDRESS (If rural, give location): 1560 Evergreen Lane

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	ALLAN	NELSON	September 9 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	April 4, 1940	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sales representative	Steel distribution	Provo, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Victor Nelson	Jensen, Utah	Venola Slaugh	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
U.S. Navy 1957 to 1961	528-52-0048	Ray W. Nelson	Orem, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple traumatic head injuries secondary to a car accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT ✓ SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Auto Accident		13

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. Mitchell	MD	L.D.S. Hosp. Idaho Falls, Ida.	9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Sept. 10, 1967	Pleasant Grove City Cem.	Pleasant Grove Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 18-1967	Irma Rudgren	Orland C. Buck	E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-630 (1)

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 24 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 7 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended April 25, 1969

Certificate of Death
STATE OF IDAHO

State File No. 67-3927
Local Reg. No. 287
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Bonneville	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): 78 yrs	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION: Sacred Heart Hospital	d. STREET ADDRESS (If rural, give location): 682 East 13th St.

3. NAME OF DECEASED (Type or Print)	a. (First): Carl	b. (Middle): Algot	c. (Last): Carlson	4. DATE OF DEATH (Month) (Day) (Year): September 12, 1967			
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: May 13, 1883	9. AGE (In years last birthday): 84	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Peace Officer, Ret.	10b. KIND OF BUSINESS OR INDUSTRY: Municipal	11. BIRTHPLACE (State or foreign country): Osage City, Kansas	12. CITIZEN OF WHAT COUNTRY: USA				
13. FATHER'S NAME: Carl John Carlson - Safsnas, Kopparberg,	BIRTHPLACE: Sweden	14. MOTHER'S MAIDEN NAME: Johanna Engstrom - Falun, Dalarna,	BIRTHPLACE: Sweden				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: Dorothy Heslop	ADDRESS: 682 East 13th, Idaho Falls				

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c) *This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.	465X MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a): Arterial thrombosis, pulmonary rt. ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b): DUE TO (c): II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death: Arteriosclerotic heart disease	INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?		

22. *I hereby certify that I attended the deceased from* 1-5- , 19 60 , *to* 9-12 , 19 67 , *that I last saw the deceased alive on* 9-12 , 19 67 , *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John S. McMillin, M.D.	23b. ADDRESS: 550 - 4th St.	23c. DATE SIGNED: 9-18-67	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Sept 16, 1967	24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	24d. LOCATION (City, town, or county) (State): Idaho Falls, Bonneville, Idaho
DATE REC'D BY LOCAL REG.: Oct 3, 1967	REGISTRAR'S SIGNATURE: Anna Bridges	25. EMBALMER: James W. Sullivan	LICENSE NO.: E-387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
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(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

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STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
APR 2 1 1969
Bureau of Vital Statistics

State of Idaho
County of Bonneville } ss

Certificate No. 67-3927

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Carl Algot Carlson (Name on Original Certificate) who died (Was Born or Died) on Sept 12, 1967 (Date of Event)
in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Personal Knowledge (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Birthplace of Father	Safsnas, Kopparberg, Germany	Safsnas, Kopparberg, Sweden
Name of Mother	Johanna Ingstrom	Johanna Engstrom
Birthplace of Mother	Safsnas, Kopparberg, Germany	Falun, Dalarna, Sweden

Subscribed and sworn to before me this 16th day of April 19 69

Estelle Duddleson

Notary Public, residing at Idaho Falls, Idaho

My commission expires June 22, 1972

(Seal)

Signed Dorothy Heslop
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

685 E 13th St, Idaho Falls, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Bonneville } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 16th day of April, 1969

Estelle Duddleson

Notary Public, residing at Idaho Falls, Idaho

My commission expires June 22, 1972

(Seal)

Signed Alta B. Havenaar
(Signature of Any Credible Person)

1375 Bower Dr, Idaho Falls Idaho
(Street Address, City, State)

FORM DN 60-155

L 12-17-68 AP

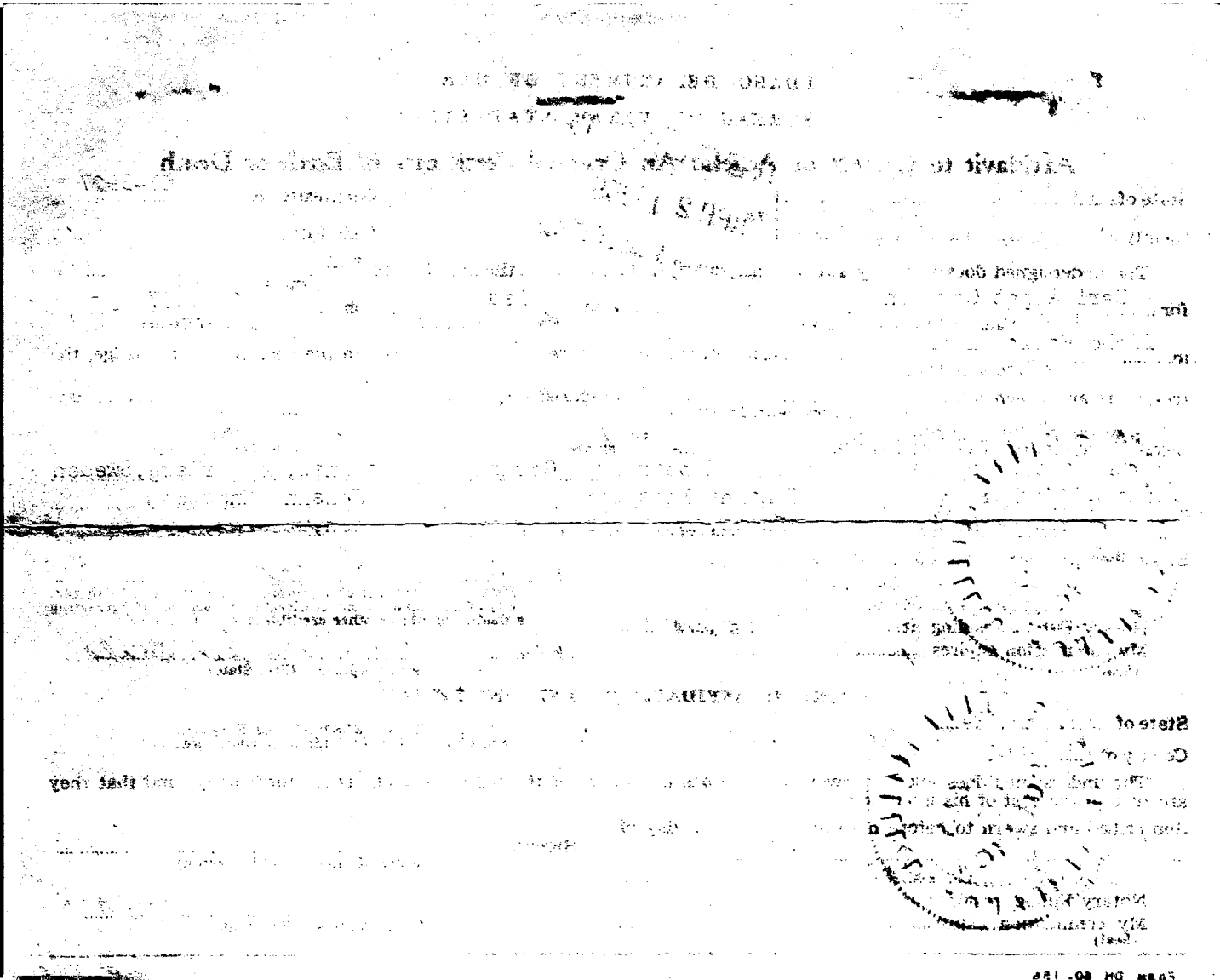

State File No. 3927
Local Reg. No. 287
Reg. Dist. No. 610

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 178
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 78 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 682 East 13th. Street

3. NAME OF DECEASED (Type or Print)
a. (First): CARL
b. (Middle): ALGOT
c. (Last): CARLSON

4. DATE OF DEATH (Month) (Day) (Year): Sept. 12, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 13, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Peace Officer, ret. 08
10b. KIND OF BUSINESS OR INDUSTRY: Municipal
11. BIRTHPLACE (State or foreign country): Osage City, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Carl John Carlson, Safsnas Kopparberg
BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Johanna Ingstrom, Safsnas Kopparberg, Germ.
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Dorothy Heslop
ADDRESS: 682 East 13th, IF, I.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

465 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arterial thrombosis, pulmonary rt.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-5-, 1960, *to* 9-12, 1967, *that I last saw the deceased alive on* 9-12, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John S. McClellan MD 348 1
23b. ADDRESS: 550 Fourth St.
23c. DATE SIGNED: 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 16 67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Bon. Idaho

DATE REC'D BY LOCAL REG.: Oct. 3 - 67
REGISTRAR'S SIGNATURE: Anna Budgier
25. EMBALMER: James W. Sullivan
LICENSE NO.: E-387
FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 5 1968

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(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
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The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 25 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3928
Local Reg. No. 271
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 10
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 795 East 14th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 348 Elaine Ave.
d. STREET ADDRESS (If rural, give location): Twin Falls, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ervin	Ray	Harding	September 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	August 22, 1892	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Law Enforcement Off	State Police	Beaver City, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elwin P. Harding	unknown	Arie Brownhard	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-16-3515	Myrtle R Harding	Twin Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4207

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cardio Vascular

DUE TO (c) Renal Disease

Old age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1940 19 *to* 9/12/ 19 67, *that I last saw the deceased alive on* July 25 1967, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
146 M.D.	594 Hazelwood Terr.	9-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	9/12/67	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Sept. 18 67	Anna Burgess	Reynolds Funeral Chapel — James C. Reynolds	Twin Falls, Idaho

1142

Federal Security Agency
United States Public Health Service

Form DPH-48021

DEC 29 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 12 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of James C. Reynolds Lic. No. E-279 at Twin Falls on 9/12/67

ADDITIONAL REMARKS by Physician

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 3929
Local Reg. No. 288
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville — OCT 9 1967 — 101 134
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls — Bureau of Vital Statistics
c. LENGTH OF (If outside place): 34 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 745 12th. Street — 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 745 12 th. Street

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLES
b. (Middle): LOREN
c. (Last): MERRILL

4. DATE OF DEATH (Month) (Day) (Year): Sept. 13, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 13, 1904
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: Automotive
11. BIRTHPLACE (State or foreign country): Cavalier, North Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Luther Merrill — BIRTHPLACE: Fairbault, Minn.
14. MOTHER'S MAIDEN NAME: Addie Louise Laudon — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-09-2690
17. INFORMANT'S OWN SIGNATURE: Elizabeth Merrill — ADDRESS: 745 12th. St. Idaho Falls, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic Heart Disease — 4 years.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 7, 1963, *to* Aug. 31, 1967, *that I last saw the deceased alive on* Aug. 31, 1967, *and that death occurred at* 2:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. K. Krantz, M.D. — 294
23b. ADDRESS: 798 South Blvd. Idaho Falls, Idaho
23c. DATE SIGNED: 9/ /67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 16, 67
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Cem.
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 3-1967
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: James W. Sullivan
LICENSE NO.: E-387

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3930
Local Reg. No. 223
Reg. Dist. No. 610

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 10 / 310
b. CITY OR TOWN: Idaho Falls
LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 10 / b. COUNTY: Bonneville
c. CITY OR TOWN: Idaho Falls
d. STREET ADDRESS (If rural, give location): 900 Memorial Drive

3. NAME OF DECEASED (Type or Print): a. (First) Elizabeth b. (Middle) c. (Last) Wetzel

4. DATE OF DEATH: (Month) (Day) (Year) September 14 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: October 15, 1889
9. AGE (In years last birthday): 77 | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Ammon, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Azariah Williams — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Elizabeth Denning — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Iona, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis 3332X — INTERVAL BETWEEN ONSET AND DEATH: about

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-6, 1957, *to* 9-14, 1967, *that I last saw the deceased alive on* 9-13, 1967, *and that death occurred at* 1:47 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 54a (Degree or title)
23b. ADDRESS: Idaho Falls, Ida
23c. DATE SIGNED: 9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/16/67
24c. NAME OF CEMETERY OR CREMATORY: Ammon Cemetery
24d. LOCATION (City, town, or county) (State): Ammon Idaho

DATE REC'D BY LOCAL REG.: Sept. 23-1967
REGISTRAR'S SIGNATURE: Lena Budge
25. EMBALMER: Ralph M. Wood [signature]
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3931
Local Reg. No. 274
Reg. Dist. No. 610

BIRTH NO.

RECEIVED SEP 27 1967 VITAL STATISTICS

1. PLACE OF DEATH
a. COUNTY: Bonneville 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY IN THIS PLACE: 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Days Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 16
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ucon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Malinda	Parlee	Bills	September 15 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	October 10, 1886	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Lawrenceburg, Tenn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Clay Harris	Tenn.	Amanda Catherine Kilburn	Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		None	Leslie Bills	Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2001 Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* October, 19 52, to Sept. 15, 19 67, *that I last saw the deceased alive on* Sept 15, 19 67, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John S Holst MD 210	Idaho Falls Idaho	9-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/18/67	Ucon Cemetery	Ucon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 23-1967	Emma Rudges	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUN 19 2006

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3932
Local Reg. No. 275
Reg. Dist. No. 210

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): N'A Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 260 b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clark
d. STREET ADDRESS (If rural, give location): Rte. #2 Rigby

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	EDWIN (EDDIE)	CHASE	Sept. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 3, 1899	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Springville, Utah.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fritz Chase	Springville, Ut.	Viola Arthusia Harrington	Springvill Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-14-8019A	Mrs Phoebe Chase	Rigby, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hydrocele, left. — 1 year

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6-14 65, 19___, *to* 9-18, 1967, *that I last saw the deceased alive on* 9-18, 1967, *and that death occurred at* 6:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Orael Hall 522	M.D.	Rigby, Idaho.	9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 21, 1967	Ririe-Shelton	Shelton Bonneville Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22-1967	Anna Rudy	Bruce A. Eckersell Bruce A. Eckersell	E-404

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Eckersell Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3933
Local Reg. No. 276
Reg. Dist. No. 6 1D

BIRTH NO.

RECEIVED OCT 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
c. LENGTH OF STAY (In this place): 60
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Iddho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley, Idaho
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Howard
b. (Middle): Alexander
c. (Last): Day

4. DATE OF DEATH: (Month) Sept (Day) 19 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 14 1906

9. AGE (In years last birthday): 61
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Building Contractor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Canistota South Ddkota

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James G. Day
BIRTHPLACE: Ireton, Iowa

14. MOTHER'S MAIDEN NAME: Jennie McDougal
BIRTHPLACE: Canisota, SD., Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 518-18-2564

17. INFORMANT'S OWN SIGNATURE: [signature]
ADDRESS: Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Anemia

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 5-26, 1964, *to* 9-19, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 9/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 22 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY: Hill Crest
24d. LOCATION (City, town, or county) (State): Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG.: Sept 21-67
REGISTRAR'S SIGNATURE: Irma Rudges

25. EMBALMER: [signature]
LICENSE NO.: E 275
FIRM NAME: L.M. Nalder

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: OCT 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Higgs

Certificate of Death

STATE OF IDAHO

State File No. 3934
Local Reg. No. 278
Reg. Dist. No. 610

RECEIVED OCT 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print)
a. (First): MARION
b. (Middle): PAUL
c. (Last): WEAVER

4. DATE OF DEATH (Month) (Day) (Year): Sept 20, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single
8. DATE OF BIRTH: 26, Oct. 1918
9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months 10, Days 24 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sugar City, Idaho
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Austin Weaver — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Florence Kidd — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Florence Kidd Weaver — ADDRESS: Idaho Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5411 Peritonitis — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Perf. Duod Ulcer — hours
DUE TO (c) Chr. Duod Ulcer — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mental Retardation — Birth

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 18 Sept, 19__, *to* death, 19__, *that I last saw the deceased alive on* 20 Sept, 1967, *and that death occurred at* 9 a.m. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas Kopp 230 MD
23b. ADDRESS: 539 - 2 St
23c. DATE SIGNED: 26 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem & Bur 3
24b. DATE: Sept 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sugar City Cemetery
24d. LOCATION (City, town, or county) (State): Sugar City, Idaho

DATE REC'D BY LOCAL REG.: Sept. 30-67
REGISTRAR'S SIGNATURE: Anna Budges
25. EMBALMER: Leo A. Williams — LICENSE NO. E-319

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended December 8, 1967

Certificate of Death

STATE OF IDAHO

State File No. 3935
Local Reg. No. 277
Reg. Dist. No. 610

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 52 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latter Day Saints Extended Care

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Georgia
b. (Middle) 042
c. (Last) Bradley

4. DATE OF DEATH (Month) (Day) (Year) September 20, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH June 23, 1890

9. AGE (In years last birthday) 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George W. Eldridge
BIRTHPLACE USA

14. MOTHER'S MAIDEN NAME Laura Leona Seeley
BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-46-4213

17. INFORMANT'S OWN SIGNATURE Barbara Mitchell
ADDRESS Idaho Falls, Idaho

18. CAUSE OF DEATH 3327
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — 3 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pyelonephritis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* Sept 20, 1967, *that I last saw the deceased alive on* Sept 19, 1967, *and that death occurred at* 7:05A m., *from the causes and on the date stated above.*

23a. SIGNATURE Byron T. Weeks, M.D. 55 (Degree or title) ✓

23b. ADDRESS 1585 So. Boulevard

23c. DATE SIGNED 9-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-23-67

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Sept 27, 1967

REGISTRAR'S SIGNATURE Anna Bridges

25. EMBALMER Ralph M. Wood

LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

67-3955

WOOD FUNERAL HOME
273 North Ridge Ave.
IDAHO FALLS, IDAHO

IDAHO DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

RECEIVED
DEC 7 1967
Bureau of Vital Statistics

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho
County of Bonneville } ss.

Certificate No.
Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for GEORGIA BRADLEY (Name on Original Certificate) who DIED (Was Born or Died) on Sept.20,1967 (Date of Event)
in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by her daughter (Bible Record, Insurance Policy, Etc.) prepared on Sept.20,1967 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Birth Date	January 23, 1890	June 23,1890

Subscribed and sworn to before me this 6th day of December, 19 67

Ralph M Wood
Notary Public, residing at Idaho Falls, Idaho
My commission expires Nov.1970
(Seal)

Signed Jack A Wood
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death records, or other credible person.)
273 North Ridge Ave. Idaho Falls, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Bonneville } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 6th day of December, 19 67

Ralph M Wood
Notary Public, residing at Idaho Falls, Idaho
My commission expires Nov 1970
(Seal)

Signed Jack A. Wood
(Signature of Any Credible Person)
273 N Ridge Ave. Idaho Falls, Idaho
(Street Address, City, State)

FORM DH 60-155

State File No. 3935
Local Reg. No. 277
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED OCT 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Bonneville 101	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho 421 b. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls c. LENGTH OF STAY (In this place): 52 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Extended Care 042	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First): Georgia	b. (Middle):	c. (Last): Bradley
4. DATE OF DEATH	(Month) September	(Day) 20	(Year) 1967
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2	8. DATE OF BIRTH: January 23, 1890
9. AGE (In years last birthday): 77	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Iowa	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: George W. Eldridge	BIRTHPLACE: USA	14. MOTHER'S MAIDEN NAME: Laura Leona Seeley	BIRTHPLACE: USA
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-46 4213	17. INFORMANT'S OWN SIGNATURE: Barbara Mitchell	ADDRESS: Idaho Fall, Ida.

332X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — 3 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pyelonephritis

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* Sept 20, 1967, *that I last saw the deceased alive on* Sept 19, 1967, *and that death occurred at* 7:05 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Byron T. Weeks MD 556	23b. ADDRESS: 1585 So. Boulevard	23c. DATE SIGNED: 9-23-67	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 9/23/67	24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery	24d. LOCATION (City, town, or county) (State): Twin Falls Idaho
DATE REC'D BY LOCAL REG.: Sept. 27-1967	REGISTRAR'S SIGNATURE: Anna A. Bridgier	25. EMBALMER: Ralph M. Wood Ralph M. Wood	LICENSE NO.: 413

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3936
Local Reg. No. 294
Reg. Dist. No. 610

Certificate of Death

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Days Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 298 5th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Grover
b. (Middle): T.
c. (Last): Bennett

4. DATE OF DEATH (Month) (Day) (Year): September 20 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 15, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer 21
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Beaver, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas J. Bennett — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Catherine Smith — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 519 01 1145
17. INFORMANT'S OWN SIGNATURE: Luila Y. Bennett — ADDRESS: Idaho Falls

465X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Rheumatic heart disease

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-8-, 1967, *to* 9-20, 1967, *that I last saw the deceased alive on* 9-20, 1967 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] McMillan 348 (Degree or title) MD 1
23b. ADDRESS: 550 Fourth St.
23c. DATE SIGNED: 9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/23/67
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county): Shelley (State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 4-1967
REGISTRAR'S SIGNATURE: Anna Bredger
25. EMBALMER: Ralph M. Wood [signature] — LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 12 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 31 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 21 1979

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Brunt

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3937
Local Reg. No. 296
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville OCT 12 1967 107
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics) Idaho Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1650 Riviera Drive

3. NAME OF DECEASED (Type or Print) a. (First) CLARA b. (Middle) JANE c. (Last) RASICOT BRUNT

4. DATE OF DEATH (Month) (Day) (Year) Sept 22, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH 19 Nov. 1878
9. AGE (In years last birthday) 88 | IF UNDER 1 YEAR Months 10 Days 3 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) aHousewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Oxford, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Alfred Rasicot BIRTHPLACE
14. MOTHER'S MAIDEN NAME Martha Thomas BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE S. Brunt ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

6000

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pyelonephritis - acute — INTERVAL BETWEEN ONSET AND DEATH 3 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. generalized arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1964, *to* Sept 22, 1967, *that I last saw the deceased alive on* Sept 22, 1967, *and that death occurred at* 5:10 pm *m., from the causes and on the date stated above.*

23a. SIGNATURE A. Wm Brunt Jr. 633 MD (Degree or title)
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 9-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept 26, 1967
24c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. Oct. 6 1967
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Leo A. Williams
LICENSE NO. E-319

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 17 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 5 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3938
Local Reg. No. 279
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1 1/2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 260
b. COUNTY: Jefferson 310
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Annis
d. STREET ADDRESS (If rural, give location): Rte. #1 Lorenzo

3. NAME OF DECEASED (Type or Print): a. (First) GERTRUDE b. (Middle) MARY c. (Last) LUDLOW

4. DATE OF DEATH (Month) (Day) (Year): Sept. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	May 28, 1899	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 01	Home	South Weber, Utah.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Bruce	Penn.	Charlotte Ellen Hill	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-26-2409 T	Kenneth Ludlow	Idaho Falls, IDaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cirrhosis alcoholic Hepatic Disease — Interval between onset and death: 1 year

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Postgenital cholecystectomy 1 week

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-27, 1966 *to* 9-23, 1967, *that I last saw the deceased alive on* 9-23, 1967, *and that death occurred at* 8:10 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 546	M.D.	Idaho Falls, Idaho.	9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sep. 26, 1967	Little Butte	Annis Jefferson Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 30-1967	[signature]	Bruce A. Eckersell Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3939
Local Reg. No. 284
Reg. Dist. No. 610

BIRTH NO. 67-8724

RECEIVED OCT 9 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 409
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 9 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley
d. STREET ADDRESS (If rural, give location): 449 So. Emmerson

3. NAME OF DECEASED (Type or Print)
a. (First): Infant
b. (Middle): None
c. (Last): CORONADO

4. DATE OF DEATH (Month) (Day) (Year): Sept. 23, 1967

5. SEX: Male
6. COLOR OR RACE: Mexican 1
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single 1
8. DATE OF BIRTH: Sept. 23, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours 9 Min. 33

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: Mexico

13. FATHER'S NAME BIRTHPLACE: Gabriel Coronado, San Louis Potosoi, Mexico
14. MOTHER'S MAIDEN NAME BIRTHPLACE: Maria Topia, San Louis Potosoi, Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Mary Coronado
ADDRESS: 449 South Emmerson

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7625

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: from birth

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Fetal atelectasis — from Birth

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 23 Sept, 1967, *to* 23 Sept, 1967, *that I last saw the deceased alive on* 23 Sept, 1967, *and that death occurred at* 10:48 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 164 [illegible]
23b. ADDRESS: Idaho Falls Ida
23c. DATE SIGNED: 24 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 2
24b. DATE: Sept. 25, 67
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest, Cemetery
24d. LOCATION (City, town, or county) (State): Shelley, Idaho

DATE REC'D BY LOCAL REG.: Oct. 3-1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E-387

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

D-07-8724

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 2 9 1992

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3940
Local Reg. No. 293
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE — OCT 9 1967
b. CITY OR TOWN: IDAHO FALLS — LENGTH OF STAY (In this place): 57 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION: 934 BANNOCK AVE.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO — b. COUNTY: BONNEVILLE
c. CITY OR TOWN: IDAHO FALLS
d. STREET ADDRESS: 934 BANNOCK AVE.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JULIUS	*	ZITLAU	SEPT.	23	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED	January 9, 1881	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
FARMER, RET.	SELF EMP.	UNKNOWN, RUSSIA	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JACOB ZITLAU	RUSSIA	SUSAN, UNKNOWN,	RUSSIA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	518-05-9940A	Martha Zitlau	934 Bannock Idaho Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Emphysema
DUE TO (c) Chronic bronchitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan '65, 19___, *to* Sept 23, 1967, *that I last saw the deceased alive on* Sept 20, 1967, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron T. Wells MD	1585 So. Boulevard	9/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	SEPT. 26, 67	FIELDING MEMORIAL CEM.	IDAHO FALLS, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 3 - 1967	Irma Budge	James [illegible]	E-387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 2 8 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 3941
Local Reg. No. 290
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
c. LENGTH OF STAY (in this place): 82
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 557 Gladstone st.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
d. STREET ADDRESS (If rural, give location): 557 Gladstone St

3. NAME OF DECEASED (Type or Print)
a. (First): WALTER
b. (Middle): EDWARD
c. (Last): ANDERSON

4. DATE OF DEATH: Sept. 23, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 11, 1884

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: Bldg. Construction

11. BIRTHPLACE (State or foreign country): Ogden, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Martin Anderson, BIRTHPLACE: Copenhagen, Denmark

14. MOTHER'S MAIDEN NAME: Amanda Drake, BIRTHPLACE: Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-05-9901

17. INFORMANT'S OWN SIGNATURE: Mrs Walt Anderson
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Previous Stroke, Hemiplegia 4 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/19, 1967, *to* 9/23, 1967, *that I last saw the deceased alive on* 9/23, 1967, *and that death occurred at* 11:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Edson Tall 52 (Degree or title): M. D.
23b. ADDRESS: Rigby, Idaho
23c. DATE SIGNED: 9/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 26, 67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 3-1967
REGISTRAR'S SIGNATURE: Emma Budge
25. EMBALMER: James A. Sullivan
LICENSE NO.: E 387
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Weeks

Cecil

Certificate of Death

STATE OF IDAHO

State File No. 3942
Local Reg. No. 261
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
OCT 5 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 10
b. CITY OR TOWN: Idaho Falls
c. LENGTH OF STAY (in this place): 080
d. FULL NAME OF HOSPITAL OR INSTITUTION: L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 10
b. COUNTY: Bonneville
c. CITY OR TOWN: Idaho Falls
d. STREET ADDRESS: 1186 Bear Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Gerald	Cecil	Crofts	Sept 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months	Days	If UNDER 24 HRS.: Hours	Min.
Male	white	married 3	August 15, 1910	57	2	19		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Iona, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William Daniel Crofts — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Margaret Ellen Crofts — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Gary E. Hulsen — ADDRESS: 695 Falls Dr. City

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Thrombosis
DUE TO (c): ASHD

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, to Sept 24, 1967, *that I last saw the deceased alive on* Sept 24, 1967, *and that death occurred at* 4:05 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Vaynor T. Wiche — (Degree or title): M.D.
23b. ADDRESS: 1585 So. Boulevard
23c. DATE SIGNED: 9-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 28 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 1-1967
REGISTRAR'S SIGNATURE: Anna Burgess
25. EMBALMER: Leo A. Williams
LICENSE NO.: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR - 3 1986

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3943
Local Reg. No. 303
Reg. Dist. No. 610

BIRTH NO.

RECEIVED OCT 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonieville
b. CITY OR TOWN: Idaho Falls
LENGTH OF STAY (in this place): 500
d. FULL NAME OF HOSPITAL OR INSTITUTION: L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 51 Wyoming
b. COUNTY: 555
c. CITY OR TOWN: Afton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lewis	Ira	Jenkins	Sept 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed	Jan 4, 1877	90	8	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer and Rancher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Newton, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Jenkins	Cowbridge, South Wales	Mary Oviatt	Council Bluffs, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs. Orlin Hokanson
ADDRESS: Freedom Wyo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) & Arterio Sclerotic Heart
DUE TO (c) Disease & Cardiac Failure
INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/12/ *, 19* 67 *, to* 9/22/67 *, 19* ___ *, that I last saw the deceased alive on* 9/22/ *, 19* 67 *and that death occurred at* 5:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. W. Corbett, M.D.	798 South Blvd. Idaho Falls, Idaho	Oct. 12, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem & Bur	27 Sept, 1967	Freedom Cemetery	Freedom, Wyoming

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 16-1967	Anna Bridges	Leo A Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 6 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 3044
Local Reg. No. 3044
Reg. Dist. No. 610

BIRTH NO.

OCT 9 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE 101 134
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
c. LENGTH OF STAY (If in this place): 34 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 206 WEST 18th ST. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 101
b. COUNTY: BONNEVILLE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location): 206 West 18th St.

3. NAME OF DECEASED (Type or Print)
a. (First): STEPHEN
b. (Middle): *
c. (Last): KOEGLER

4. DATE OF DEATH (Month) (Day) (Year): Sept. 24, 1967

5. SEX: Male
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: MAY 6, 1885
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NOTEL OPERATOR 26
10b. KIND OF BUSINESS OR INDUSTRY: HOTEL
11. BIRTHPLACE (State or foreign country): BENCHEK, HUNGARY
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JOHN KOEGLER, BIRTHPLACE: HUNGARY
14. MOTHER'S MAIDEN NAME: MARION DICKHOFF, BIRTHPLACE: HUNGARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-20-3099
17. INFORMANT'S OWN SIGNATURE: Elsa Koegler — ADDRESS: 206 W. 18th. Idaho Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

584 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Biliary cirrhosis — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Choledocholithiasis
DUE TO (c): Cholecystitis — 2 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1965, *to* Sept, 1967, *that I last saw the deceased alive on* Sept 15, 1967, *and that death occurred at* 5:30 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Byron T Weeks MD 556 1
23b. ADDRESS: 1585 So. Boulevard
23c. DATE SIGNED: 9/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: SEPT. 27, 67
24c. NAME OF CEMETERY OR CREMATORY: ROSEHILL CMEMTERY
24d. LOCATION (City, town, or county) (State): IDAHO FALLS, IDA.

DATE REC'D BY LOCAL REG.: Oct. 3-1967
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: James H. Sullivan — LICENSE NO. E-387
FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 19 1967 Bureau of Vital Statistics

State File No. 3945
Local Reg. No. 299
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
Length of STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 474 I St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 13 Idaho b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 474 I St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	EMMETT	C	WALKER	Sept 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married 3	1 Feb. 1890	77	8	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Businessman 24	wholesale Grocery	La Belle, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Winslow F. Walker...	Salt Lake City, Ut.	Sarah Melissa Scott	Mill Creek, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		Norma L. Walker	586 10th E Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic H D
DUE TO (c) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 19 46, *to* Sept, 19 67, *that I last saw the deceased alive on* 9-25-67, 19 , *and that death occurred at* m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
210 [illegible] MD	Idaho Falls, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	28 Sept 1967	Rosehill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 10-1967	Emma Budge	Leo T. Williams	E-389

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Williams Funeral Home

DUTIES:

OCT 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 9 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 20 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3946
Local Reg. No. 292
Reg. Dist. No. 610

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY BONNEVILLE 101 OCT 9 1967 15
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 538 WALNUT ST. Ida Falls
c. LENGTH OF STAY IN THIS PLACE 75 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 538 WALNUT ST. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 101
b. COUNTY BONNEVILLE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) IDAHO FALLS
d. STREET ADDRESS (If rural, give location) 538 WALNUT ST.

3. NAME OF DECEASED (Type or Print) a. (First) CHARLOTTE b. (Middle) * c. (Last) KINNEY

4. DATE OF DEATH (Month) (Day) (Year) SEPT. 25, 1967

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2
8. DATE OF BIRTH MAY 20, 1882
9. AGE (In years last birthday) 82 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 61
10b. KIND OF BUSINESS OR INDUSTRY HOME
11. BIRTHPLACE (State or foreign country) ALAMEDA, CALIFORNIA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME CHARLES CHRISTIAN TAUTPHAUS, BIRTHPLACE Alsace Lorainne, France
14. MOTHER'S MAIDEN NAME SARAH KANE BIRTHPLACE CLARK, IRELAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 712-07-9596
17. INFORMANT'S OWN SIGNATURE R. J. Kinney ADDRESS Orofino, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4201 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Heart Disease — 10 yrs
DUE TO (c) Angina, and #2 — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arthritis — 20 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 9/25/67, 19__, *that I last saw the deceased alive on* 9/14/67, 19__, *and that death occurred at* 2:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE N B Buck MD (Degree or title)
23b. ADDRESS Idaho Falls, Ida
23c. DATE SIGNED 9/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE SEPT 27, 67
24c. NAME OF CEMETERY OR CREMATORY ROSEHILL CEMETERY
24d. LOCATION (City, town, or county) IDAHO FALLS, (State) IDAHO

DATE REC'D BY LOCAL REG. Oct. 3-67
REGISTRAR'S SIGNATURE Emma Budge
25. EMBALMER Thomas W Sullivan
LICENSE NO. E 387
FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3947
Local Reg. No. 295
Reg. Dist. No. 610

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 309
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LIMITS OF STAY (in this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 205 East 16th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Ocie
b. (Middle): Ethel
c. (Last): Snow

4. DATE OF DEATH (Month) (Day) (Year): September 27 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: January 8, 1891
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Lawrence County, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert E. Stansell — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Susan Meador — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Mrs Jack Kissner — ADDRESS: Idaho Falls Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

592X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic Nephritis — INTERVAL BETWEEN ONSET AND DEATH: 10 years?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: C.V.A. — 4 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 15, 1967, *to* Sept 27, 1967, *that I last saw the deceased alive on* Sept 27, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 196 MD
23b. ADDRESS: Idaho Falls Ida
23c. DATE SIGNED: 9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/30/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Oct. 4-1967
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood [signature]
LICENSE NO.: 413

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 39484
Local Reg. No. 293
Reg. Dist. No. 6/0

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
Statistics OF STAY (in this place): 6 D
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Greenview Chalet Nursing Home 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 23 / b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 75 East 2nd North St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Thorn	O.	Bird	September 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	December 24, 1897	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 07	Farm	Montpelier, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew James Bird	Springville, Utah	Cynthia Osborn	Hyrum, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-44-1895	Grace B. Bird	Rexburg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia 493X	1 week
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Chronic brain syndrome	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept. 19 67 *to* 28 Sept, 1967, *that I last saw the deceased alive on* 27 Sept, 1967, *and that death occurred at* 5:[illegible] P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dan O. Johnson 262 MD	Idaho Falls, Idaho	2 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/2/67	Fielding Memorial Park	Idaho Falls Bonneville Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 2-67	Verna Rudges	Dennis B. Flamm	E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 12 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3949
Local Reg. No. 300
Reg. Dist. No. 610

RECEIVED OCT 19 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 112 South Water Ave

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edmund	M.	Ingram	September 30 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced	June 1, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Telephone Company	Overton, Nevada	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Ingram	USA	Eliza Roundy	USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 07 2553	Ralph Kelly Ingram	Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral hemorrhage	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hypertensive arteriosclerotic heart disease	18 hrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan. 1953, *to* Sept. 30 1967, *that I last saw the deceased alive on* 9-30, 1967, *and that death occurred at* 6:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
X C. Blair Ellsworth M.D.	Idaho Falls, Idaho	10-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/4/67	Ammon Cemetery	Ammon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 12 - 67	Bruce Burgess	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 17 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3950
Local Reg. No. 39-67
Reg. Dist. No. 100

RECEIVED SEP 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NW Corner Sect. 13
LENGTH OF STAY (in this place): 2 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Tnship 60 N Range 3 W 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 27 Montana
b. COUNTY: 555 Sanders
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Trout Creek
d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print): a. (First) Merle b. (Middle) Lee c. (Last) Collins

4. DATE OF DEATH (Month) (Day) (Year): Sept. 1, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 25, 1917

9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heavy Equipment Operator - logging

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oregon

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter Collins — BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Laura Hankins — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: unobtainable

17. INFORMANT'S OWN SIGNATURE: X Nancy Collins — ADDRESS: Trout Cryk Mont.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Smoke inhabitation and asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: 1 - 3 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Forest Fire
DUE TO (c): Trapped in fast moving fire

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Kaniksu Natl Forest
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 NW Corn Sec 13 Tnship 60 N Range 3W, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 1, 1967 6P m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Escape cut off by forest fire

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. M. Callahan 583 Coroner 4
23b. ADDRESS: Box 302 Bonners Ferry Idaho
23c. DATE SIGNED: 9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Sept 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: Whitepine Cemetery
24d. LOCATION (City, town, or county) (State): Whitepine, Montana

DATE REC'D BY LOCAL REG.: 9-8-67
REGISTRAR'S SIGNATURE: Tawyla Stone

25. EMBALMER: L. G. Moon, Jr. — LICENSE NO.: E-405

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3951
Local Reg. No. 38-67
Reg. Dist. No. 100

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NW Corner Sec 13 Tnshp 60 N Range 3 West
c. LENGTH OF STAY (in this place): 2 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 05 California
b. COUNTY: 555 Santa Barbara
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Santa Maria
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Luther	Peter	Rodarte	Sept. 1, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White 08	Married 3	July 17, 1931	36				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ast. Fire Cont. Officer	U.S.Forest Serv.	California	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John B. Rodarte	Mexico	Ida Buelna	California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	1948 - 1950 6	546-40-0518	Personal papers	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Smoke inhalation and asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: 1 - 3 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Forest Fire - Sundance Fire
DUE TO (c): Trapped in fast moving fire

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Kaniksu Natl. Forest	NW Corner Sec. 13 Tnship 60N Rg 3 W, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Sept 1, 1967 6P m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Escape cut off by forest fire

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Callahan Coroner 583	Bonners Ferry, Idaho	9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Sept 3, 1967		Santa Maria, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-6-67	Twyla Stone	L. G. Moon, Jr.	E-405

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 12 1967

AUG 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3952
Local Reg. No. 43-67
Reg. Dist. No. 100

SEP 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 6 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 110
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): 703 S. Main Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Mary	Florence	Sundeen		9	15	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married 5	7-26-1896	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Jewet Mills, Wisc.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Patrick Henry Joyce	Ireland	Rebecca Mayberry	Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-28-1965B
17. INFORMANT'S OWN SIGNATURE: Jan Nelson (Daughter) ADDRESS: Foresthill, Calif.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Myocarditis
DUE TO (c) Senile Atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Senile Dementia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug., 1967, *to* Sept 9, 1967, *that I last saw the deceased alive on* 9/9, 1967, *and that death occurred at* 3:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Fred W. Denver 150	MD	Bonners Ferry, Idaho	9/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-19-67	Grandview Cemetery	Bonners Ferry Boundary Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-26-67	Virgia Stone	Wendell Malone	E453

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

SEP 2 8 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 9 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3953
Local Reg. No. 45-67
Reg. Dist. No. 100

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 1day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 110
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDWARD	ANTON	VOLD	September 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	October 7, 1891	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Vold, Norway	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Anton Vold	Norway	Anna Otterholm	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 4281	519-18-2323	Mary A Vold	Bonners Ferry Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD — unknown

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/27, 1967, *to* 9/28, 1967, *that I last saw the deceased alive on* 9/28, 1967, *and that death occurred at* 6 p.c. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 103	MD	Bonners Ferry Ida	10/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/2/67	Parker Cemetery	BonnersFerry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 4, 1967	Twyla Stone	[signature]	E-453

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3954
Local Reg. No. 5
Reg. Dist. No. 670

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Butte 120 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 190
b. COUNTY: Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Darlington
d. STREET ADDRESS (If rural, give location): 4 mi. NE of Darlington

3. NAME OF DECEASED (Type or Print)
a. (First): BELVA
b. (Middle): BROWN
c. (Last): JONES

4. DATE OF DEATH (Month) (Day) (Year): Sept. 14, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 4
8. DATE OF BIRTH: Jan. 4, 1907
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: Teaching
11. BIRTHPLACE (State or foreign country): Ogden, Utah
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Harry D. Brown — BIRTHPLACE: Harrisville, Utah
14. MOTHER'S MAIDEN NAME: Goria Folkman — BIRTHPLACE: Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 528-10-3816
17. INFORMANT'S OWN SIGNATURE: X Goria Jones Powell — ADDRESS: Santa Clara, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1750

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Carcinoma of Ovary — 5 yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 20, 1967, *to* Sept 14, 1967, *that I last saw the deceased alive on* Sept 14, 1967, *and that death occurred at* 2:45p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. F. Barker M.D.
23b. ADDRESS: Arco, Idaho
23c. DATE SIGNED: 9-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-18-67
24c. NAME OF CEMETERY OR CREMATORY: Hooper Cemetery
24d. LOCATION (City, town, or county) (State): Hooper, Utah

DATE REC'D BY LOCAL REG.: 9-30-67
REGISTRAR'S SIGNATURE: Betty J. Marvel
25. EMBALMER: E. H. Marvel
LICENSE NO.: E-457

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 11 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 9 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 14 1978

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3955
Local Reg. No. 6
Reg. Dist. No. 670

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Butte
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Lost Rivers Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 190
b. COUNTY: Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): CORY
b. (Middle): DEAN 000
c. (Last): SAVAGE

4. DATE OF DEATH: (Month) (Day) (Year): September 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	Nov. 30, 1959	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	None	Bridgeport, Conn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Bill N. Savage	Salmon, Idaho	Rella Wood	Tremonton, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		None	Bill N. Savage	Challis, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8134

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): multiple injuries - Head injury — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Concussion, Laceration,
DUE TO (c): Fractured skull, chest injury

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: abdominal injury

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Street 04	B Challis 190	Custer	Ida

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
9	19	67	5:45		Car hit bicycle

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____ *and that death occurred at* 9:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. Bartel M.D.		Arco, Idaho	9-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-22-67	Challis Cemetery	Challis, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-30-1967	Betty J. Marvel	C. H. Marvel	E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3956
Local Reg. No. 94
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO. 67-8782 RECEIVED SEP 28 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell Idaho
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 141 Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): Caldwell Hospital

3. NAME OF DECEASED (Type or Print)
a. (First): SAUL
b. (Middle):
c. (Last): DeLEON

4. DATE OF DEATH (Month) 8 (Day) 27 (Year) 67

5. SEX: M
6. COLOR OR RACE: Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant 1
8. DATE OF BIRTH: 8/27/67
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours 5 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Caldwell, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME / BIRTHPLACE: Jose DeLeon Rangerville, Texas
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Raquel Reyna Stockdale, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE / ADDRESS: X Ramiro DeLeon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pre-natal + Post Natal depression

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cause not fully known, but infant was second of very premature twins
DUE TO (c) born at 6½ months gestation

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Child lived nearly 5 hours. Lack of mature vitality was probably the basic cause of death. Whether aspiration of mucus & atelectasis occurred is not known

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 27, 1967, *to* Aug 27, 1967, *that I last saw the deceased alive on* Aug 27, 1967, *and that death occurred at* near noon *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): S. W. Kellogg 275 M.D. 1
23b. ADDRESS: 1201 S. Kimball Caldwell Ida
23c. DATE SIGNED: 14 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8/29/67
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 27, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17, to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3957
Local Reg. No. 70
Reg. Dist. No. 360

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 007
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 423 Fern

3. NAME OF DECEASED (Type or Print): a. (First) Simon b. (Middle) c. (Last) Opp

4. DATE OF DEATH (Month) (Day) (Year): Sept. 1, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 13, 1887

9. AGE (In years last birthday): 80 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): South Russia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Christian Opp — BIRTHPLACE: Russia

14. MOTHER'S MAIDEN NAME: Magdalene Welz — BIRTHPLACE: Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 723-03-0119

17. INFORMANT'S OWN SIGNATURE: Katie Opp — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4280

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* Sept 1, 1967, *that I last saw the deceased alive on* Sept 1, 1967, *and that death occurred at* 11:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 326 — **23b. ADDRESS**: Nampa Idaho — **23c. DATE SIGNED**: 9/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Entombment

24b. DATE: Sept. 5, 1967

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mausoleum

24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE RECD BY LOCAL REG.: Sept. 11, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: [signature] — LICENSE NO.: E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Wesche

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3958
Local Reg. No. 68
Reg. Dist. No. 360

BIRTH NO.

SEP 13 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 20 yrs. 120
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Rt 6

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	Rose		Butler

4. DATE OF DEATH: (Month) Sept. (Day) 2, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	11-11-1872	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife 01	Own	Mountain City, Nev.	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Hover	Germany	Shubert Schisebert	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			X Louis B Butler	Nampa

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Hemorrhage	3 hrs
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Asteriosclerotic Cardio Vas. Dis	yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-25-, 1962, *to* 9-2-, 1962, *that I last saw the deceased alive on* 9-2-, 1967, *and that death occurred at* 5:37 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald E Wesche MD	MD	Nampa Idaho	9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-6-1967	Valleyview Cemetery	Vale, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 11, 1967	Mrs. Martina Walmsley	Robert J. Bertelson	Ore. 107

FIRM NAME: BERTELSON LINKAMPER FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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VI -

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 11 1967 Bureau of Vital Statistics

State File No. 3959
Local Reg. No. 66
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Caldwell, Idaho
LENGTH OF STAY (If not in place of death): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakely Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 14
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): 613 Dearborn

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
MARGARET	MARY	TROESCHER	9	3	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widowed 2	March 21, 1881	86	5	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Newport, Kentucky
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George F. Kessen — BIRTHPLACE: Essen, Germany
14. MOTHER'S MAIDEN NAME: Henrietta M Brown — BIRTHPLACE: Cincinnati, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: x Frances M. Byer — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Prk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. CVA — 5 year

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug, 1962 *to* Sept 3, 1967, *that I last saw the deceased alive on* Sept, 1967, *and that death occurred at* 1020 m *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Val E Ryther MD	Caldwell Idaho	Sept 6 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/6/67	Canyon Hill	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 7, 1967	Mrs Martina Walmsley	Leonard C. Flahiff	E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3960
Local Reg. No. 63
Reg. Dist. No. 360

RECEIVED SEP 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 007
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1711 Fifth Street North

3. NAME OF DECEASED (Type or Print)
a. (First): Lawrence
b. (Middle):
c. (Last): Eshelman

4. DATE OF DEATH: (Month) Sept. (Day) 7, (Year) 1967.

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Jan. 27, 1903

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Trash Hauler 06

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Fontanelle, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Ellis Eshelman
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Anna Faith Clayton
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Alossie V. Rouse
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Sigmoid Volvulus & Obstruction of Colon

4201

19a. DATE OF OPERATION: Aug. 16, 1967

19b. MAJOR FINDINGS OF OPERATION: Obstructive Sigmoid Volvulus

20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 8/14, 19 67, *to* 9/3, 19 67, *that I last saw the deceased alive on* 9/3, 19 67, *and that death occurred at* 7:05P m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. R. Mangum 322 (Degree or title): MD

23b. ADDRESS: Nampa, Idaho.

23c. DATE SIGNED: 9/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 6, 1967

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Ada County, Idaho

DATE REC'D BY LOCAL REG.: Sept. 6, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Richard W. Messbrook

LICENSE NO.: E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 10 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 22 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3961
Local Reg. No. 82
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 624-16 Avenue South

3. NAME OF DECEASED (Type or Print): a. (First) GRACE; b. (Middle) M.; c. (Last) PERKINS

4. DATE OF DEATH: (Month) September (Day) 4, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 14, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Edgar Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Hayden — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Mary Cline — BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 22 7643
17. INFORMANT'S OWN SIGNATURE: Lewis A Perkins Jr — ADDRESS: Salem, Ore.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio selerosis - generalized — 30+ yrs.
DUE TO (c) Coronary Atherosclerosis — 30+ yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Lymphosarcome of leg — 2+ yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 Aug, 1967, *to* 4 Sept, 19 67, *that I last saw the deceased alive on* Aug 17, 19 67, *and that death occurred at* 7:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: B B Riordan 443 (Degree or title): MD
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 10 Sept '67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: Sept. 20, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Meserve
LICENSE NO.: E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3962
Local Reg. No. 75
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 007
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, 212 Morrison St. 007

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 14
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 212 Morrison

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Floy	L.	Anderson	Sept. 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	June 23, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Pawnee County, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arch Dugan	Iowa	Rosa Jane Nelson	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	479-46-0133	Lena Blankenburg	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Coron 4201	5 minutes
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	A S H D	10 yr
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes	4 mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan 16, 1966, *to* Aug 16, 1967, *that I last saw the deceased alive on* Aug 16, 1967, *and that death occurred at* 7:38 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Neil E. Reinhart MD	Caldwell	9/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 8, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 15, 1967	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Peckham-Dakan, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 9 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

State File No. 3963
Local Reg. No. 69
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 145
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa -Rural
d. STREET ADDRESS (If rural, give location): Route # 3

3. NAME OF DECEASED (Type or Print): a. (First) ELLEN; b. (Middle) S.; c. (Last) BURTON

4. DATE OF DEATH (Month) (Day) (Year): September 4, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: October 21, 1889
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Scipio Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Soren Christian Nielson — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME: Anna Christine Anderson — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 16 6350
17. INFORMANT'S OWN SIGNATURE: E. S. Burton — ADDRESS: Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Diabetis — Yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-0- , 1965, *to* 9-4- , 1967, *that I last saw the deceased alive on* 9-4- , 1967, *and that death occurred at* 7:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Gerald E Wenke 559 (Degree or title) MD
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 9-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Ada Idaho

DATE REC'D BY LOCAL REG.: Sept. 11, 1967
REGISTRAR'S SIGNATURE: Mrs. Martha Walmsley
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3964
Local Reg. No. 71
Reg. Dist. No. 360

Certificate of Death

RECEIVED SEP 14 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Mercy Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 224 Young St.

3. NAME OF DECEASED (Type or Print)
a. (First): Douglas
b. (Middle): B
c. (Last): Holly

4. DATE OF DEATH (Month) (Day) (Year): Set. 4, 1967'

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 24, 1930
9. AGE (In years last birthday): 36 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpet Layer 06
10b. KIND OF BUSINESS OR INDUSTRY: Carpet
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Floyd G. Holly — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Daisy Emrich — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes 7/31/56-7/26.58 6
16. SOCIAL SECURITY NO.: 371-30-8880
17. INFORMANT'S OWN SIGNATURE: Mrs. Wilma R. Holly — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 4½ yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) hypercholesterolemia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-7- *, 19*63*, to* 9-4- *, 19*67*, that I last saw the deceased alive on* 8-30- *, 19*67*, and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert E. Day M.D. 217
23b. ADDRESS: 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED: 9-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kuna Cemetery
24d. LOCATION (City, town, or county) (State): Kuna Idaho

DATE REC'D BY LOCAL REG.: Sept. 13, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Larry J. Krouch
LICENSE NO.: E-447

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED SEP 22 1967

Certificate of Death

STATE OF IDAHO

State File No. 3965
Local Reg. No. 83
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 306
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 38 Oregon 555
b. COUNTY: Malheur
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ontario
d. STREET ADDRESS (If rural, give location): 766 S. E. 2nd Street

3. NAME OF DECEASED (Type or Print)
a. (First): Tsurukichi
b. (Middle):
c. (Last): Ishida

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1967

5. SEX: Male
6. COLOR OR RACE: Japanese 5
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 2, 1889
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Arg.
11. BIRTHPLACE (State or foreign country): Okayama Ken Japan
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unk — BIRTHPLACE: Unk
14. MOTHER'S MAIDEN NAME: Unk. — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: R3 Parma

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction and congestive heart failure.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Urinary obstruction

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-31-67, 19__, *to* 9-4-67, 19__, *that I last saw the deceased alive on* 9-4-67, 19__, *and that death occurred at* 1:40 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE W J Hubler 250 (Degree or title) MD
23b. ADDRESS: 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED: 9-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial Removal
24b. DATE: 9-8-1967
24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
24d. LOCATION (City, town, or county) (State): Ontario Oregon

DATE REC'D BY LOCAL REG.: Sept. 21, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Robert J Bertelsen
LICENSE NO.: Ore. 107
FIRM NAME: Bertelson-Lienkuemper

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 5 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3966
Local Reg. No. 67
Reg. Dist. No. 360

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakely's Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 9 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Greenleaf
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Theodore
b. (Middle): Leetus
c. (Last): Williams

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 10, 1878
9. AGE (In years last birthday): 88 — If under 1 year: Months 11, Days 25 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lynville, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richmond Williams — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Josophime Mendenhall — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-42-1940
17. INFORMANT'S OWN SIGNATURE: Mrs. Dorwin E. Smith — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of the prostate with metastases. — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): advanced age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1965
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of the prostate
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1955, to Sept 5, 1967, that I last saw the deceased alive on Sept 2, 1967, and that death occurred at 9 A m., from the causes and on the date stated above.*

23a. SIGNATURE: Charles E Kemmerer 280 (Degree or title): MD
23b. ADDRESS: 1819 Ellis St Caldwell Idaho
23c. DATE SIGNED: 9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenleaf Cemetery
24d. LOCATION (City, town, or county) (State): Greenleaf, Idaho

DATE REC'D BY LOCAL REG.: Sept. 11, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E 508

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3967
Local Reg. No. 73
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 1 DAY 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 142
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 1523 7th STREET NORTH

3. NAME OF DECEASED (Type or Print)
a. (First): EVA
b. (Middle): JANE
c. (Last): STARR

4. DATE OF DEATH (Month) (Day) (Year): SEPT. 7, 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2
8. DATE OF BIRTH: MARCH 23, 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME MAKER 01
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): OREGON
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JAMES M. ENGLAND — BIRTHPLACE: NO RECORD
14. MOTHER'S MAIDEN NAME: NELLIE HARRISON — BIRTHPLACE: OREGON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-32-3859
17. INFORMANT'S OWN SIGNATURE: X Ernest E. Starr — ADDRESS: NAMPA, IDAHO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4211

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Ischemia c/c Ventricular Tachycardia — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c): Aortic Stenosis Insuff — 2 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 16, 19__, *to* Sept, 1967, *that I last saw the deceased alive on* Sept 7, 1967, *and that death occurred at* 12:10P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Graydon O. Cron 115 — **23b. ADDRESS**: NAMPA, IDAHO — **23c. DATE SIGNED**: 9-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 9-11-67
24c. NAME OF CEMETERY OR CREMATORY: KOHLERLAWN CEMETERY
24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Sept. 14, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd — LICENSE NO. 473

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHEPHERD MORTUARY

DUTIES:

OCT 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3968
Local Reg. No. 74
Reg. Dist. No. 360

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 135-1st-St. North Ext. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 135-1st St. North Ext.

3. NAME OF DECEASED (Type or Print)
a. (First): Lucy
b. (Middle):
c. (Last): Mangum

4. DATE OF DEATH (Month) (Day) (Year): September 10, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 31, 1896
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: homemaking
11. BIRTHPLACE (State or foreign country): Hooper, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Smith — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Butler — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-12-7283B
17. INFORMANT'S OWN SIGNATURE: X Earl Mangum — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1530 Cancer Cecum — INTERVAL BETWEEN ONSET AND DEATH: 7 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 2-23-67
19b. MAJOR FINDINGS OF OPERATION: Cancer Cecum & metastases to lymph nodes
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-23, 1967, *to* 9-10, 1967, *that I last saw the deceased alive on* 9-6, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 166
23b. ADDRESS: Caldwell Ida
23c. DATE SIGNED: 9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 12, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens
24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE REC'D BY LOCAL REG.: Sept. 15, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 19 1967 Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3969
Local Reg. No. 79
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 411 Bird St.

3. NAME OF DECEASED (Type or Print): a. (First) Etta; b. (Middle) Mae; c. (Last) Loudenslager

4. DATE OF DEATH (Month) (Day) (Year): September 10, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 27, 1870

9. AGE (In years last birthday): 96 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Defiance, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ridenour — BIRTHPLACE: Maryland

14. MOTHER'S MAIDEN NAME: Annie Flaugher — BIRTHPLACE: Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 445-40-8473-A

17. INFORMANT'S OWN SIGNATURE: Mrs Fred E Johnson — ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia - Sclerotic C V Disease — INTERVAL BETWEEN ONSET AND DEATH: Yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Fractured Left Humeral neck

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-3-, 19 67 *to* 9-10-, 1967, *that I last saw the deceased alive on* 9-10-, 1967, *and that death occurred at* 9-30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Gerald E Wesche 559 (Degree or title) MD

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: Sept. 15, 1967

24c. NAME OF CEMETERY OR CREMATORY: Waukomis Cemetery

24d. LOCATION (City, town, or county) (State): Waukomis, Oklahoma

DATE REC'D BY LOCAL REG.: Sept. 18, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Richard W. Messebrink — LICENSE NO.: E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 28 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3970
Local Reg. No. 72
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 4 MO. 204
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 603 5th ST. SOUTH 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 142
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA,
d. STREET ADDRESS (If rural, give location): 603 5th ST. SOUTH

3. NAME OF DECEASED (Type or Print)
a. (First): ROGER
b. (Middle): C.
c. (Last): THOMAS

4. DATE OF DEATH (Month) (Day) (Year): SEPT. 10, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: DEC. 18, 1885
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED POLICE OFFICER 08
10b. KIND OF BUSINESS OR INDUSTRY: POCATELLO
11. BIRTHPLACE (State or foreign country): CLINTON, MISSOURI
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GEORGE L. THOMAS — BIRTHPLACE: NO RECORD
14. MOTHER'S MAIDEN NAME: JESSIE NO RECORD — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-32-1543
17. INFORMANT'S OWN SIGNATURE: x J. M. Polinski — ADDRESS: POCATELLO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gunshot wound chest — self inflicted 926X

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 2 Suicide 26
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): In his car. 13
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Nampa 142 Canyon Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 10 - 1967 7:40 A.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: Shot himself with a 38 revolver.

22. *I hereby certify that I attended the deceased from* Inspection only, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 7:40A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesche M.D. 583 Coroner 4
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 9-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 9-14-67
24c. NAME OF CEMETERY OR CREMATORY: MT. MORIAH CEMETERY
24d. LOCATION (City, town, or county) (State): POCATELLO, IDAHO

DATE REC'D BY LOCAL REG.: Sept. 14, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 19 1967

OCT 23 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3971
Local Reg. No. 86
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 14 Canyon SEP 26 1967
b. CITY OR TOWN Caldwell, Ida
c. LENGTH OF STAY IN THIS PLACE 66?
d. FULL NAME OF HOSPITAL OR INSTITUTION Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 14
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) Route # 5

3. NAME OF DECEASED (Type or Print) a. (First) KERRY b. (Middle) 05 c. (Last) JEMMETT

4. DATE OF DEATH (Month) 9 (Day) 10 (Year) 67

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Child 7

8. DATE OF BIRTH April 6, 1964

9. AGE (In years last birthday) 3 IF UNDER 1 YEAR Months 5 Days 4 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Boise, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME F. Grant Jemmett BIRTHPLACE Shelley, Ida.

14. MOTHER'S MAIDEN NAME Vendla Robison BIRTHPLACE Rexburg, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE ADDRESS x F. Grant Jemmett

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Head Injuries — INTERVAL BETWEEN ONSET AND DEATH 1½ hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Run over by a
DUE TO (c) hay wagon

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe chest Injury

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm 02

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 Notus, 14 Canyon, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 10, 1967 6:45 P.M.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Fell off moving tractor

22. *I hereby certify that I attended the deceased from* _____, 1966, *to* 10 Sep, 1967, *that I last saw the deceased alive on* 10 Sep, 1967, *and that death occurred at* 8:20 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Charles E. Krause 295 (Degree or title) M.D.

23b. ADDRESS Caldwell Idaho

23c. DATE SIGNED 19 Sep 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/14/67

24c. NAME OF CEMETERY OR CREMATORY Hillcrest

24d. LOCATION (City, town, or county) (State) Near Nampa, Idaho

DATE REC'D BY LOCAL REG. Sept. 25, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Lucy M. Flahiff

LICENSE NO. F393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 19 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3972
Local Reg. No. 78
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): + HRS 404
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 142
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 712 12th AVE. SOUTH

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ED	W.	ROBB	SEPT. 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE 10	MARRIED 3	NOV. 1, 1901	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RET. DIST. STOREKEEPER	P.F.E.	PUEBLO, COLORADO	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
HARRY A. ROBB	IOWA	FLORENCE EVANS	MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		700-09-3346	X Mrs E.W. Robb	NAMPA, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 6-27, 1966, *to* 9-11, 1967, *that I last saw the deceased alive on* 9-11, 1967, *and that death occurred at* 3:35P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J.C. Horton MD 245		NAMPA, IDAHO	9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	9-14-67	KOHLER LAWN CEMETERY	NAMPA, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 18, 1967	Mrs. Martina Walmsley	R. B. Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 31 1986

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3973
Local Reg. No. 80
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 19 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 12
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa Rural Rt. #2
d. STREET ADDRESS (If rural, give location): Rural Rt. #2 Nampa

3. NAME OF DECEASED (Type or Print): a. (First) Mary; b. (Middle) Walmsley; c. (Last) Nichol

4. DATE OF DEATH: (Month) (Day) (Year): Sept. 12, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: October 26, 1909

9. AGE (In years last birthday): 57 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Parma, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred J. Walmsley — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Jennie Price — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-30-0502

17. INFORMANT'S OWN SIGNATURE: Fred K Nichol — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

3317

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage was

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) left hemiplegia -
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-1, 1965, *to* 9-12-, 1967, *that I last saw the deceased alive on* 9-12-, 1967, *and that death occurred at* 8:40 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wesche 560 (Degree or title) M.D.

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 9-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/14/67

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens

24d. LOCATION (City, town, or county) (State): Canyon Idaho

DATE REC'D BY LOCAL REG.: Sept. 18, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: [signature] LICENSE NO. E-476

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 23 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 5 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3974
Local Reg. No. 88
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (in this place) 40
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rt. #3 Nampa
d. STREET ADDRESS (If rural, give location) Rt. #3 Nampa

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) Louise c. (Last) Lewis

4. DATE OF DEATH (Month) (Day) (Year) September 13, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH November 22, 1890
9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Homemaking
11. BIRTHPLACE (State or foreign country) Hamilton County, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry C. Sundermeier BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Louise Oestricher BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-54-3254
17. INFORMANT'S OWN SIGNATURE X Mrs. H. Lewis ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of gall bladder — INTERVAL BETWEEN ONSET AND DEATH 3 mos known

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION June 29/67
19b. MAJOR FINDINGS OF OPERATION Carcinoma of gall bladder & tending to liver
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 29, 1967, *to* Sept 13, 1967, *that I last saw the deceased alive on* Sept 13, 1967, *and that death occurred at* 2:45 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.
23b. ADDRESS 824-17th Ave So, Nampa
23c. DATE SIGNED Sept 21/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 15, 1967
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State) NAMPA Idaho

DATE REC'D BY LOCAL REG. Sept. 26, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Larry D. Krouse
LICENSE NO. E-447
FIRM NAME Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3975
Local Reg. No. 92
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
141
SEP 28 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 702 South Kimball

3. NAME OF DECEASED (Type or Print)
a. (First): Martin
b. (Middle): G.
c. (Last): Skaar

4. DATE OF DEATH (Month) (Day) (Year): Sept. 13, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 5, 1904
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager of Federal Land
10b. KIND OF BUSINESS OR INDUSTRY: Bank of Caldwell
11. BIRTHPLACE (State or foreign country): La Crosse, Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin Skaar 26 — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Lillian Hall — BIRTHPLACE: Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 540-36-6581
17. INFORMANT'S OWN SIGNATURE: Vera Skaar — ADDRESS:

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-1-64, 19__, *to* 9-13-67, 19__, *that I last saw the deceased alive on* 9-13-67, 19__, *and that death occurred at* 5:00P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. Hubler 250 (Degree or title): MD
23b. ADDRESS: 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED: 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 27, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E-508

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record, typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 9 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 27 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 5 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3976
Local Reg. No. 81
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 22 1967 Bureau of Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place) 100
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 15

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). 142
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Midland Manor Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First) Arthur b. (Middle) Leroy c. (Last) Selby

4. DATE OF DEATH (Month) (Day) (Year) September 14, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH June 24, 1879

9. AGE (In years last birthday) 88 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer 04

10b. KIND OF BUSINESS OR INDUSTRY farming

11. BIRTHPLACE (State or foreign country) Boone County, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Harrison Selby
BIRTHPLACE Indiana

14. MOTHER'S MAIDEN NAME Clarissa Richey
BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) Sp.-Am. War

16. SOCIAL SECURITY NO. 519-32-8684

17. INFORMANT'S OWN SIGNATURE James Selby ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Occlusion Left Cerebral

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) artery arteriosclerosis
DUE TO (c) Congestive heart failure

INTERVAL BETWEEN ONSET AND DEATH
14 Days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Prostate stroke

332X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 4, 1967 *to* Sept. 14, 1967 *that I last saw the deceased alive on* Sept. 14, 1967 *and that death occurred at* 2:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 16a

23b. ADDRESS Caldwell Idaho

23c. DATE SIGNED 9-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 18, 1967

24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) Nampa (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 20, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Richard W. Meeuwsen

LICENSE NO. E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3977
Local Reg. No. 90
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Memorial Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1820½ So. Kimball

3. NAME OF DECEASED (Type or Print)
a. (First): Minnie
b. (Middle): May
c. (Last): Mayberry

4. DATE OF DEATH (Month) (Day) (Year): Sept. 14, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Jan. 11, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dora, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Upshaw — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Lilly Bennett — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-26-9902
17. INFORMANT'S OWN SIGNATURE: x Bob Mayberry — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Occlusion

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection only *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wesche M.D. Coroner 4 583 560
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 9-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Garden
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 26, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E-50

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 3978
Local Reg. No. 85
Reg. Dist. No. 360

BIRTH NO.

SEP 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN: Caldwell
LENGTH OF STAY (in this place): DD
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Notus
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Asa	W.	Andrews	Sept. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed 2	Nov. 21, 1876	90		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29		Parma, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Andrews	England	Jane Mansell	Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-10-7422A	John Andrews	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion	0
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Cardio-Vascular Disease	30 yrs.
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Urinary Obstruction due to urethral stricture	1 week

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 1945, *to* 15 Sept, 1967, *that I last saw the deceased alive on* 15 Sept, 1967, *and that death occurred at* 5:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D. D. Simpson	M.D.	Caldwell	19 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 19, 1967	Lower Boise Cemetery	Parma, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 22, 1967	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

MAR 15 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 17 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 3979
Local Reg. No. 101
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 4 1967 Vital Statistics Bureau of Health

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middleton
LENGTH OF STAY (in this place): 88
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Middleton Canal 140

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middleton
d. STREET ADDRESS (If rural, give location): Box 104

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Tinsley	McCreary	Sept. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 2	Nov. 12, 1888	78	10	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29		Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wm T. McCreary	Montana	Mary Pinnegar	South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unknown	519-12-7706	Floyd H. McCreary	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9298

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
1	18	13 140

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Inspection only, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Wesche M.D. 583 Coroner	Nampa Idaho	9-29-67.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 29, 1967	Middleton Cemetery	Middleton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 3, 1967	Mrs. Martina Walmsley	Kenneth E Jones	C-396

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3980
Local Reg. No. 84
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 143 105
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 5 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital-Nampa 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 511- 20th Ave. So.

3. NAME OF DECEASED (Type or Print)
a. (First): Geneva
b. (Middle): Marcelle
c. (Last): Easterling

4. DATE OF DEATH (Month) (Day) (Year): Sept. 15, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: May 1, 1920
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months 4, Days 14 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Family Records, By: Jerry J. Krouch

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

205X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mycosis Fungoides — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1964, *to* Sept, 1967, *that I last saw the deceased alive on* Sept 15, 1967, *and that death occurred at* 12:00 Noon, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gayden O'Crow 115 (Dr)
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 9-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Transportation 3
24b. DATE: 9/18/67
24c. NAME OF CEMETERY OR CREMATORY: Alridge Ridge Cem.
24d. LOCATION (City, town, or county) (State): Bonham, Texas

DATE REC'D BY LOCAL REG.: Sept. 22, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3981
Local Reg. No. 87
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Mercy Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 604-19th Ave. So.

3. NAME OF DECEASED (Type or Print)
a. (First): Norman
b. (Middle): Henry
c. (Last): Stengel

4. DATE OF DEATH (Month) (Day) (Year): September 15, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: November 2,1893
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired contractor
10b. KIND OF BUSINESS OR INDUSTRY: building
11. BIRTHPLACE (State or foreign country): Jefferson, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Erhardt Stengel — BIRTHPLACE: Bavaria
14. MOTHER'S MAIDEN NAME: Anna Zeh — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. I 3
16. SOCIAL SECURITY NO.: 518-28-7020
17. INFORMANT'S OWN SIGNATURE: Margaret E. Hamilton — ADDRESS:

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection only, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wesche Mr R. Corona ¢ ~~560~~ 538
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 9-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 19, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: Sept. 26, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature]
LICENSE NO.: E-496

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 19 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3982
Local Reg. No. 93
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place) 12 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 112 Delaware Street

3. NAME OF DECEASED (Type or Print) a. (First) GENE b. (Middle) COATES c. (Last) SOLLENDER

4. DATE OF DEATH (Month) (Day) (Year) Sept. 16, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Dec. 4, 1919

9. AGE (In years last birthday) 47
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24

10b. KIND OF BUSINESS OR INDUSTRY Hafco Company

11. BIRTHPLACE (State or foreign country) Blackfoot, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE

14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II 4

16. SOCIAL SECURITY NO. 518-12-7272

17. INFORMANT'S OWN SIGNATURE Linda C. Sells ADDRESS 4033 Chinden Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac - arrythmia - Ventr. Tachycardia - Fib — 6 hrs to 2 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Gastric hem. - exsanguination gastric - greater curvature — 30+ hrs.

DUE TO (c) Peptic ulcer - gigantic 4"x4" cm — yrs 4 plus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Atherosclerosis - Coronaries - + general — 10 yrs
Gastritis - Chronic — 4-10 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/15, 1967, to 9/16, 1967, *that I last saw the deceased alive on* 9/16, 1967, *and that death occurred at* 5:00 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS Nampa, Idaho

23c. DATE SIGNED 9/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE 9-20-67

24c. NAME OF CEMETERY OR CREMATORY Mtn. View Memorial

24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 27, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER F. Richard Reed

LICENSE NO. E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 6 1968

FEB 6 1968

MAR 6 1970

SEP 9 1985

MAR 18 1987

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 13 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 3983
Local Reg. No. 118
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL NAMPA
d. STREET ADDRESS (If rural, give location): ROUTE 6

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN	J.	ROYER	SEPT. 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED 3	JUNE 24, 1899	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED RANCHER 04	RANCHING	GRACEVILLE, MINN.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
DOMICK ROYER	NO RECORD	ROSA NO RECORD	NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		Virginia Royer	NAMPA, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4344

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Apparent Heart Attack — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
	Home	Nampa Canyon Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
9 16 1967 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John W. Glenn	588 Physician	C. House, Caldwell, Ida.	Oct. 10, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	9-20-67	WIESER CEMETERY	WIESER, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 12, 1967	Mrs. Martina Walmsley	M. B. Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3984
Local Reg. No. 103
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa, Idaho
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): 1619 So. Kimball

3. NAME OF DECEASED (Type or Print)
a. (First): ELSIE
b. (Middle): MAY
c. (Last): BIEBER

4. DATE OF DEATH (Month) 9 (Day) 17 (Year) 67

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married / 09
8. DATE OF BIRTH: Oct. 30, 1897
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months 10, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Calvert, Norton Co. Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas A. Bieber — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Effie G Venosdel VanBuren — BIRTHPLACE: Co. Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-58-9575
17. INFORMANT'S OWN SIGNATURE: x Guy E. Bieber — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5272

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Kyphoscoliotic Lung disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-12-, 1967, *to* 9-17-, 1967, *that I last saw the deceased alive on* 9-17-, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: R.C. Jeager M.D. 666 (Degree or title) /
23b. ADDRESS: 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED: 9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/20/67
24c. NAME OF CEMETERY OR CREMATORY: Wilder
24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: Oct. 5, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff — LICENSE NO. E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3985
Local Reg. No. 97
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 702 So. 7th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	K.	Horrace	Sept. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	July 26, 1879	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29		Pegram, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Horrace	Unknown	Rachael Caldwell	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE + J. LeRoy Horrace	ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4658 Acute pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis — 10 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-27-59, 19____, *to* 9-18-67, 19____, *that I last saw the deceased alive on* 9-18-67, 19____, *and that death occurred at* 5:40A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. R. Peckham M.D.	222 East Elm--Caldwell, Idaho	9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 21, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 29, 1967	Mrs. Martina Walmsley	Merville D. Davis	E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3986
Local Reg. No. 91
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
SEP 28 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 60
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1907 Blaine St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Joy	F.	Corn	Sept. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	March 8, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None		Middleton, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel S. Foote	Conn.	Cordelia Wilson	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		E. F. Corn	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Leiomyosarcoma, Right Kidney — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
5/17/67	Leiomyosarcoma, right kidney	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/30, 1967, *to* 9/19, 1967, *that I last saw the deceased alive on* 9/19, 1967, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jerald C. Bauman M.D.	Caldwell Idaho	9/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 22, 1967	Middleton Cemetery	Middleton, Idaho

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 27, 1967	Mrs. Martina Walmsley	Melville D. Davis	E-399

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3987
Local Reg. No. 98
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO. 67-7659

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1718 3rd St. No.

3. NAME OF DECEASED (Type or Print)
a. (First): Donna
b. (Middle):
c. (Last): Linze

4. DATE OF DEATH (Month) (Day) (Year): Sept. 20, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: August 24, 1967
9. AGE (In years last birthday): If under 1 year: Months / Days 26; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Donald Montgomery
BIRTHPLACE: Oklahoma
14. MOTHER'S MAIDEN NAME: Shirley Linze
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S OWN SIGNATURE: Rucker Wm Linze
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7630

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth, 19__, *to* Sept 20, 1967, *that I last saw the deceased alive on* Sept 20, 1967, *and that death occurred at* 5:35 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Graydon D Crow 115
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 9-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 29, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D Davis
LICENSE NO.: E-399

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3988
Local Reg. No. 89
Reg. Dist. No. 360

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
Duration of STAY (in this place): 00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, 1604 S. Kimball 00

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1604 So. Kimball

3. NAME OF DECEASED (Type or Print): a. (First) Anna; b. (Middle) E.; c. (Last) McLeod

4. DATE OF DEATH (Month) (Day) (Year): Sept. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
Female	White	Widowed	January 31, 1878	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Devonshire, England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Purser — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Eliza Goodyear — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-38-5145
17. INFORMANT'S OWN SIGNATURE: Eleanor K. Thompson — ADDRESS:

4221

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — 2 wks
DUE TO (c) Arteriosclerotic Cardio Vascular disease — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Parkinsonism — 14 yr.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1954, *to* Sept 20, 1967, *that I last saw the deceased alive on* 20 Sept, 1967, *and that death occurred at* 1:43 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: A. D. Thompson 413 (Degree or title): MD 91
23b. ADDRESS: Caldwell
23c. DATE SIGNED: 22 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Entombment
24b. DATE: Sept. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mausoleum
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Sept. 26, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D. Davis — LICENSE NO.: E-399
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

JUL 16 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased,

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3989
Local Reg. No. 95
Reg. Dist. No. 360

RECEI

Certificate of Death

STATE OF IDAHO

SEP 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Rt. # 5, Box 189

3. NAME OF DECEASED (Type or Print)
a. (First): Amanda
b. (Middle): S.
c. (Last): Corn

4. DATE OF DEATH (Month) (Day) (Year): Sept. 22, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 3, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hermitage, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Laffette Hitson — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Mary j. Dollarhide — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-40-1299B
17. INFORMANT'S OWN SIGNATURE: Ross Corn — ADDRESS: RG #1 Box 421 Ont Ore

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left cerebral artery insufficiency "CVA" — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) hypertension
DUE TO (c) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept 10, 1967, *to* Sept 22, 1967, *that I last saw the deceased alive on* 9-22, 1967, *and that death occurred at* 2A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 166 — **23b. ADDRESS**: Caldwell, Ida — **23c. DATE SIGNED**: 9-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Sept. 28, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Rodney W. Dakan
LICENSE NO.: E-508

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 26 1968

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 25 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3990
Local Reg. No. 96
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 16 days 316
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 380
b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): Route #2 - SE New Plymouth

3. NAME OF DECEASED (Type or Print)
a. (First): REES
b. (Middle): BYRON
c. (Last): BYRAM

4. DATE OF DEATH (Month) (Day) (Year): September 22, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 28, 1881
9. AGE (In years last birthday): 86 — If under 1 year: Months - Days - — If under 24 hrs.: Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lemuel Wade Byram — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Amanda Crawford — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: 519-40-1953
17. INFORMANT'S OWN SIGNATURE: Dean Byram — ADDRESS: New Plymouth, Ida.

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 7 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Gastric ulcer

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): - - - - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): - - - - - - - - - -
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): - - - - - - - - - - - - - - - - - -
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - - - - - - m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: - - - - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* 11-26-60, 19__, *to* 9-22-67, 19__, *that I last saw the deceased alive on* 9-22-67, 19__, *and that death occurred at* 7:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 250 (Degree or title): M.D.
23b. ADDRESS: Caldwell, Idaho
23c. DATE SIGNED: 9-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial 3
24b. DATE: Sept. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Park View Cemetery
24d. LOCATION (City, town, or county): New Plymouth — (State): Idaho

DATE REC'D BY LOCAL REG.: Sept. 29, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shaffer Memory Chapel-

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3991
Local Reg. No. 102
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 88
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 150

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Nevada
b. COUNTY: Humboldt
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Winnemucca
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Inez	Pia	Lupien	Sept. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	April 7, 1915	52		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Jordan Valley, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Larrusea	Spain	Florentina Urresti	Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	530-10-2210	Mrs Ed Carta	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

163X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pleura +
DUE TO (c) Lung

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov, 1966 *to* Sept 23, 1967, *that I last saw the deceased alive on* Sept 23, 1967, *and that death occurred at* 5:00 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
S C Taylor M.D. 524	619 Canyon Nampa	9/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Sept. 27, 1967	Winnemucca Cemetery	Winnemucca, Nevada

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 3, 1967	Mrs. Martina Walmsley	Melville D. Davis	E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 17 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3992
Local Reg. No. 99
Reg. Dist. No. 360

RECEIVED OCT 3 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkview Manor Nursing Home 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Rt. #1, Nampa
d. STREET ADDRESS (If rural, give location): Rural Rt. #1, Nampa

3. NAME OF DECEASED (Type or Print)
a. (First): Elgie
b. (Middle):
c. (Last): Wintrode

4. DATE OF DEATH (Month) (Day) (Year): September 25, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: October 14, 1883
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Fairchild, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Burnie — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Margaret Holmes — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-58-9663
17. INFORMANT'S OWN SIGNATURE: Helen Edson — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-25-~~47~~ 1949, *to* 9-25, 1967, *that I last saw the deceased alive on* 8-17, 1967, *and that death occurred at* 6:32 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): T C Horton MD 248
23b. ADDRESS: 1223-7 St So, Nampa
23c. DATE SIGNED: 9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: Oct. 2, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature] — LICENSE NO. F-496

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3993
Local Reg. No. 100
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 4 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Box 313

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): H.
c. (Last): Allender

4. DATE OF DEATH (Month) (Day) (Year): Sept. 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 1, 1877
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fairfield, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Emery Allender — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Anna Stones — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 468-34-5891T
17. INFORMANT'S OWN SIGNATURE: H. S. Allender — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9030

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic cardio-vasc. disease — 20 yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Rib fractures - R 5, 6, 7, 8. — 1 mo.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Parma 140 Canyon Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 1 1967 ? m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? fall in home

22. *I hereby certify that I attended the deceased from* 4 Aug, 1967, *to* 28 Sept, 1967, *that I last saw the deceased alive on* 28 Sept, 1967, *and that death occurred at* 3:45 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: S. D. Simpson 413 M.D. 1 (Degree or title)
23b. ADDRESS: Caldwell
23c. DATE SIGNED: 30 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Roswell Cemetery
24d. LOCATION (City, town, or county) (State): Roswell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 3, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D. Davis
LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 4 1967

NOV 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 3994
Local Reg. No. 105
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 6 1967 Bureau of Vital Statistics STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 12 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY IN (In this place): 50
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 12 b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 1411-11th Ave South

3. NAME OF DECEASED (Type or Print): a. (First) Frank b. (Middle) P. c. (Last) Alverson

4. DATE OF DEATH (Month) (Day) (Year): September 27, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 10 3

8. DATE OF BIRTH: June 30, 1891.

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Locomotive Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Hope, Kentucky.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Justus Alverson — BIRTHPLACE: No Record

14. MOTHER'S MAIDEN NAME: No Record — BIRTHPLACE: No Record.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 707-18-3360A

17. INFORMANT'S OWN SIGNATURE: Mrs Vernon Staka — ADDRESS: Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro Vasc Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arthritis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour):

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Sept 27 1967, *that I last saw the deceased alive on* Sept, 1967, *and that death occurred at* 5:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John B. Marquiss MD

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 10/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 29, 1967

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Oct. 5, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: John F. Alsip Jr.

LICENSE NO.: E-361

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 17 1976

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3995
Local Reg. No. 104
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED OCT 6 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 880
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 123 Elder

3. NAME OF DECEASED (Type or Print)
a. (First): Cuma
b. (Middle): L.
c. (Last): McIntire

4. DATE OF DEATH (Month) (Day) (Year): September 29, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 18, 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Mt. Grove, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Holt — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Nancy E. Gilley — BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-18-2540D
17. INFORMANT'S OWN SIGNATURE: Clara M. Witte — ADDRESS: Nampa

18. CAUSE OF DEATH 4221
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 Day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteria Sclerosis, Cardiac Vas. Dis. — Yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Small bowel obstruction — 2 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-26, 1967, *to* 9-29, 1967, *that I last saw the deceased alive on* 9-29, 1967, *and that death occurred at* 7:10 A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gerald E. Nescha MD 559
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county): Nampa — (State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 5, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Larry J. Kowalski — LICENSE NO.: E-447

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3996
Local Reg. No. 115
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 500
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Caldwell Mem. Hospital 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Rt. # 3, Nampa

3. NAME OF DECEASED (Type or Print)
a. (First): DEO
b. (Middle): WALTER
c. (Last): POOLEY

4. DATE OF DEATH (Month) (Day) (Year): Sept. 29, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 7/27/99
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY: Dry Cleaning
11. BIRTHPLACE (State or foreign country): Fedora, South Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Pooley — BIRTHPLACE: Michigan
14. MOTHER'S MAIDEN NAME: Addie Phillips — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 552-10-3353
17. INFORMANT'S OWN SIGNATURE: Mrs. Maude Pooley — ADDRESS: Rt. # 3, Nampa

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-21-66, 19__, *to* 9-29-67, 19__, *that I last saw the deceased alive on* 9-27-67, 19__, *and that death occurred at* 10:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. Nobleman 250 (Degree or title)
23b. ADDRESS: 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED: 10-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/2/67
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county): Nampa (State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 12, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Larry J. Krouse
LICENSE NO.: E-447
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 21 1967 Bureau of Vital Statistics

State File No. 3997
Local Reg. No. 5
Reg. Dist. No. 520-521

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Caribou 150 108
b. CITY OR TOWN Soda Springs Hospital (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place) 8 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Caribou County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 150 b. COUNTY Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs, Idaho
d. STREET ADDRESS (If rural, give location) 341 So Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	John	William	Sparks	Sept. 16 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Sept. 1 1939	28				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Employee of	Wells Cargo	Montpelier Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elliott Sparks	Dingle Idaho	Nona Rowland	Dingle Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Mrs. Margene Sparks	Soda Springs

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8160

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Concussion Head Injury — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 150 (COUNTY) (STATE)
Accident	Street 04	125 Soda Springs, Caribou, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
9 16 67 7:40 A.M.		Pick up truck he was driving was hit by Logger truck.

22. *I hereby certify that I attended the deceased from* Sept 16, 1967, *to* Sept 16, 1967, *that I last saw the deceased alive on* Sept 16, 19 67, *and that death occurred at* 9:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen H. Hall 534 M.D.	Soda Springs, Ida	9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Sept. 20 1967	Dingle Cemetery	Dingle Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-18-67	Darle Cherrett	Nile Matthews	E35-9

FIRM NAME Whitaman Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-69021

SEP 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 28 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 4 1967

FEB 28 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3998
Local Reg. No.
Reg. Dist. No. 520-521

Certificate of Death

STATE OF IDAHO

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Bancroft
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 150
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Bancroft
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Clair Whitworth Hatch

4. DATE OF DEATH (Month) (Day) (Year): Sept. 20, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: March 23, 1937
9. AGE (In years last birthday): 30 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Bancroft, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Asa F. Hatch — BIRTHPLACE: Hatch, Idaho
14. MOTHER'S MAIDEN NAME: Elizabeth Whitworth — BIRTHPLACE: Brigham City, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Carole Hatch — ADDRESS: Bancroft, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9121

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Skull fracture

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): On a Farm
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Bancroft 150 Caribou Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 20, 1967 m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Combine harvester overturned and was pinned beneath.

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Theodore S Allen 583 Coroner
23b. ADDRESS: Soda Springs, Idaho
23c. DATE SIGNED: 9/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/23/67
24c. NAME OF CEMETERY OR CREMATORY: Chesterfield Cemetery
24d. LOCATION (City, town, or county) (State): Chesterfield, Idaho

DATE REC'D BY LOCAL REG.: 9-22-67
REGISTRAR'S SIGNATURE: Darhl Cheirett
25. EMBALMER: Theodore S Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 29 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 24 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 3999
Local Reg. No. 7
Reg. Dist. No. 520-521

Certificate of Death

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Bancroft
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 150
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Bancroft
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): John Francis Butterfield, Sr.

4. DATE OF DEATH (Month) (Day) (Year): Sept. 22, 1967

5. SEX: male
6. COLOR OR RACE: white 21
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: June 24, 1899
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter-retired
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Lava Hot Springs, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Charles Butterfield — BIRTHPLACE: Oxford, Ida.
14. MOTHER'S MAIDEN NAME: Adelia Quigley — BIRTHPLACE: Clarkston, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W.W.I 3
16. SOCIAL SECURITY NO.: 519-01-1197
17. INFORMANT'S OWN SIGNATURE: Edwin K. Butterfield — ADDRESS: Bancroft, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8160

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fracture & brain damage — INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (Dead on arrival at Hospital)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Road 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Soda Springs, 150 Caribou, Idaho.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9-22-67 4:30 PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Pick up he was driving was hit broadside by grain truck

22. *I hereby certify that I attended the deceased from* 9/22, 1967 *to* 9/22, 1967 *that I last saw the deceased alive on* Jan, 1967, *and that death occurred at* 4:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Allen H. 834 Tigor J. M.D
23b. ADDRESS: Soda Springs, Idaho
23c. DATE SIGNED: 9/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/26/67
24c. NAME OF CEMETERY OR CREMATORY: Bancroft Cemetery
24d. LOCATION (City, town, or county) (State): Bancroft, Idaho

DATE REC'D BY LOCAL REG.: 10-5-67
REGISTRAR'S SIGNATURE: Darhl Cherrett
25. EMBALMER: Theodore A Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 8 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4000
Local Reg. No. 8
Reg. Dist. No. 520-521

Certificate of Death

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs, Idaho
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou Co. Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 150
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs, Idaho
d. STREET ADDRESS (If rural, give location): 201 N. 1st E.

3. NAME OF DECEASED (Type or Print)
a. (First): Ernest
b. (Middle):
c. (Last): Breitenbuecker

4. DATE OF DEATH (Month) (Day) (Year): Sept 30 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Mar 28 1905
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Logan, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward E. Breitenbuecker — BIRTHPLACE: Bissengen Germany
14. MOTHER'S MAIDEN NAME: Hermine Hochstrasser — BIRTHPLACE: Lausen Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-01-2465
17. INFORMANT'S OWN SIGNATURE: Della Breitenbeker — ADDRESS: Soda Springs Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1550 Primary Cancer of Liver — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* 30 Sept, 1967, *that I last saw the deceased alive on* Sept 30, 1967, *and that death occurred at* 11:06 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Allen H. Tigert, M.D. 530
23b. ADDRESS: Soda Springs, Idaho
23c. DATE SIGNED: 10-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 3, 1967
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: 10.5.67
REGISTRAR'S SIGNATURE: Darhl Cheerrett
25. EMBALMER: Nile Matthews
LICENSE NO.: E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Whitman Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 23 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 1 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4001
Local Reg. No. 1745
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 3 yrs 103
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burley Nursing Home 290

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 160
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Albion
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Jennie
b. (Middle): Harris
c. (Last): Bell

4. DATE OF DEATH (Month) (Day) (Year): Sept. 1, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 11, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Park City, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph D. Harris — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Mary C. Rooker — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Leo R Bell — ADDRESS: Albion

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from May 1, 1964, to Sept 1, 1967, that I last saw the deceased alive on approx Aug, 1967, and that death occurred at 1:15 a.m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 283 Md. 1
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 9/6/1967
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Heyburn, Idaho

DATE REC'D BY LOCAL REG.: Sept. 11 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E 389

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4002
Local Reg. No. 1746
Reg. Dist. No. 470

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia /6/ 149
b. CITY OR TOWN: Burley
LENGTH OF STAY (in this place): 49 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho /6/ b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 1434 Oakley Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Ethel b. (Middle) c. (Last) Gummerson

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 3, 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 28, 1885

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months 4, Days 6 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Nevada, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hyrum Swafford — BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Marion Bennett — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 518-48-8502

17. INFORMANT'S OWN SIGNATURE: Beulah Williams — ADDRESS: Burley Ida R3 Box 204

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriosclerotic Cardiovascular Disease

DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hypertension Internal — 15 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 24 May, 1950, *to* 9-3, 1967, *that I last saw the deceased alive on* 9-3, 1967, *and that death occurred at* 8:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS: Burley, Idaho

23c. DATE SIGNED: 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Sept. 7, 1967

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Sept. 12 1967

REGISTRAR'S SIGNATURE: Ruth H. Pearson

25. EMBALMER: Ormand J. Bench — LICENSE NO.: E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 19 1967

FEB 14 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4003
Local Reg. No. 1747
Reg. Dist. No. 470

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 160
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Hwy 30 S
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Eight Mi. North of Strevell

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 45 Utah 555
b. COUNTY: Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salt Lake City
d. STREET ADDRESS (If rural, give location): 1375 Hudson

3. NAME OF DECEASED (Type or Print)
a. (First): Kathleen
b. (Middle): 000
c. (Last): Crane

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1967

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: May 9, 1949
9. AGE (In years last birthday): 18 — IF UNDER 1 YEAR: Months 3, Days 27 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Payson, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James H. Crane — BIRTHPLACE: no data
14. MOTHER'S MAIDEN NAME: Carol Cox — BIRTHPLACE: no data

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: 529-70-7295
17. INFORMANT'S OWN SIGNATURE: Beverly Hollrook — ADDRESS: 3251 So 2309 E Salt Lake City, Utah

18. CAUSE OF DEATH 8254
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): massive right chest injury and torn liver — INTERVAL BETWEEN ONSET AND DEATH: moments

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: none
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06 Rural Highway 13
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Cassia County Idaho 160
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9-5-67 8:30 a.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Investigated the death of

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* about 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Leslie L Fillmore MD 165 1 (Degree or title)
23b. ADDRESS: Box 657 Burley Idaho
23c. DATE SIGNED: 9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Sept. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Wasatch Lawn Cemetery
24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: Sept. 12, 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

DUTIES:

SEP 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended April 15, 1971

Certificate of Death

STATE OF IDAHO

State File No. 4004
Local Reg. No. 1744
Reg. Dist. No. 470

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 21 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): R.F.D. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 161
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): R.F.D.

3. NAME OF DECEASED (Type or Print)
a. (First): Gary
b. (Middle): Lee
c. (Last): Simmons

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Nov. 28, 1965
9. AGE (In years last birthday): 1 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ******* 02
10b. KIND OF BUSINESS OR INDUSTRY: *******
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: U. Dean Simmons — BIRTHPLACE: Burley, Idaho
14. MOTHER'S MAIDEN NAME: Blanche Koyle — BIRTHPLACE: Burley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: U. Dean Simmons — ADDRESS: Burley, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9290

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Drowing — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 01 Home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Burley 161 Cassia Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Fellin watering trough

22. *I hereby certify that I attended the deceased from* Investigated the death *, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 6:45 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE: Leslie L. Fillmore MD 165 (Degree or title) 1
23b. ADDRESS: Box 657 Burley, Ida
23c. DATE SIGNED: 9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9/8/67
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Sept 11 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 9 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
APR 9 1971
Bureau of Vital Statistics

State of Idaho
County of Cassia } ss.

Certificate No. 67-4004

Date Filed

The undersigned does solemnly swear that certain facts in the certificate of ~~birth~~ death (Birth or Death)
for Gary Lee Simmons (Name on Original Certificate) who died (Was Born or Died) on Sept. 5, 1967 (Date of Event)
in Cassia County (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#24b [redacted]	September 6, 1967	SEPT. 8, 1967
(Date of Burial)		

Subscribed and sworn to before me this 6th day of April, 1971

Notary Public, residing at Burley, Idaho
My commission expires Notary Public Residing at Burley, Idaho
(Seal) My Commission Expires December 19, 1973

Signed [signature]
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

221 West Main - Burley, Ida.
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of
County of } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 6th day of April, 1971

Notary Public, residing at Burley, Idaho
My commission expires Notary Public Residing at Burley, Idaho
(Seal) My Commission Expires December 19, 1973

Signed Quin Lee Hansen
(Signature of Any Credible Person)

1950 Burton Ave.
(Street Address, City, State)

Form DH 60-155

AUG 21 1975

State File No. 4005
Local Reg. No. 1748
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 16 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 4 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 470

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 160
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bridge
d. STREET ADDRESS (If rural, give location): R.F.D. Near Malta

3. NAME OF DECEASED (Type or Print)
a. (First): Deloros
b. (Middle): Montana
c. (Last): Newbold

4. DATE OF DEATH (Month) (Day) (Year): Sept. 9, 1967

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 1, 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Douglass, Arizona
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Clarence L. Potter - Fort Dodge, Iowa
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Pearl Minnie American Falls, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 544-12-2630
17. INFORMANT'S OWN SIGNATURE: Leonard Newbold — ADDRESS: Auburn, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Uremia	3 weeks
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Chronic nephritis + pyelonephritis	8 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes mellitus	10 years
	Arteriosclerotic Heart Disease	10 year

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1954, *to* Sept 9, 1967, *that I last saw the deceased alive on* Sept 9, 1967, *and that death occurred at* 1:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. R. Kircher M.D. 283
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 9/12/67
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Heyburn, Idaho

DATE REC'D BY LOCAL REG.: Sept 15, 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: J. Garth Sayre
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4006
Local Reg. No. 1749
Reg. Dist. No. 470

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY IN THIS PLACE: 60
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 340 b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paul
d. STREET ADDRESS (If rural, give location): *********

3. NAME OF DECEASED (Type or Print)
a. (First): John b. (Middle): 070 c. (Last): Eifer

4. DATE OF DEATH: (Month) Sept. (Day) 9, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 14, 1875

9. AGE (In years last birthday): 92 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Retired)

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Schleswig-Holstein, Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jes Eifer — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 519-18-7944

17. INFORMANT'S OWN SIGNATURE: Marie E. Jochnowitz — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Bladder Obstruction — 9-7-67
DUE TO (c): Prostatic hypertrophy

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Gen Arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr. —, 19 1967 *to* 9-9-, 1967, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D. — **23b. ADDRESS**: Burley, Idaho — **23c. DATE SIGNED**: 9-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial — **24b. DATE**: 9/13/67 — **24c. NAME OF CEMETERY OR CREMATORY**: Pleasant View — **24d. LOCATION** (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Sept 18, 1967 — REGISTRAR'S SIGNATURE: Ruth H. Pearson — **25. EMBALMER** — LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4007
Local Reg. No. 1750
Reg. Dist. No. 470

BIRTH NO.

SEP 25 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 160
b. COUNTY: Cassia 314
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elba
d. STREET ADDRESS (If rural, give location): * * * * * *

3. NAME OF DECEASED (Type or Print)
a. (First): Stephen
b. (Middle): Rowan
c. (Last): Tucker

4. DATE OF DEATH: Sept. 14, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Sept. 18, 1885

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired School Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Education

11. BIRTHPLACE (State or foreign country): Livia, Kentucky

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ebenezer Wilson Tucker
BIRTHPLACE: Livia, Ky.

14. MOTHER'S MAIDEN NAME: Martha Allen Miller
BIRTHPLACE: Lawrenceburg, Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): 1908-1911

16. SOCIAL SECURITY NO.: 518-14-3284

17. INFORMANT'S OWN SIGNATURE: Gladys T. Barker
ADDRESS: Elba, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Arteriosclerotic Heart Disease	5 years
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Uremia	2 weeks
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 6, 1965, *to* Sept. 14, 1967, *that I last saw the deceased alive on* Sept 14, 1967, *and that death occurred at* 8:20 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.

23b. ADDRESS: 1341 Overland Ave., Burley, Idaho

23c. DATE SIGNED: 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 9/23/67

24c. NAME OF CEMETERY OR CREMATORY: McCall Cemetery

24d. LOCATION (City, town, or county) (State): McCall, Idaho

DATE REC'D BY LOCAL REG.: Sept 20 1967

REGISTRAR'S SIGNATURE: Beck H. Pearson

25. EMBALMER: Garth Payne

LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 2 1967

DEC 3 0 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4008
Local Reg. No. 1753
Reg. Dist. No. 470

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place) life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 200 So. 290 West

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 161
b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 200 So. 290 West

3. NAME OF DECEASED (Type or Print) a. (First) Delon b. (Middle) Anderson c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH May 10, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 4 Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 02
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Burley, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gale LaMont Anderson-Boise, Idaho
14. MOTHER'S MAIDEN NAME Shirlene Afton Baker-Burley, Idaho
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) — — — —
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE La Mont Anderson ADDRESS Burley, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

7954

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Natural Causes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Infant had been ill - was put to bed for night and found dead in crib an hour later

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) none
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Burley (COUNTY) Cassia (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Did Not See Alive, 19—, that I last saw the deceased alive on —, 19—, and that death occurred at — m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) Rev. G. Mitchell Sheriff
23b. ADDRESS R#2 Burley Idaho
23c. DATE SIGNED 9-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/18/1967
24c. NAME OF CEMETERY OR CREMATORY Pleasant View Cemetery
24d. LOCATION (City, town, or county) Burley, Idaho (State)

DATE REC'D BY LOCAL REG. Sept. 27, 1967
REGISTRAR'S SIGNATURE Ruth N. Pearson
25. EMBALMER
LICENSE NO. E 389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: b-67-4526 OCT 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4009
Local Reg. No. 1751
Reg. Dist. No. 470

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION: 4½ Miles West Hwy #30

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): 435 West Hwy #30

3. NAME OF DECEASED (Type or Print): a. (First) Frederick b. (Middle) L c. (Last) Oliver

4. DATE OF DEATH: (Month) Sept. (Day) 16, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: June 22, 1950

9. AGE (In years last birthday): 17
IF UNDER 1 YEAR: Months 2, Days 25
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Torrington, Wyoming

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Oliver,
BIRTHPLACE: Wyoming

14. MOTHER'S MAIDEN NAME: Betty Goltz
BIRTHPLACE: Cottier, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 488-54-4668

17. INFORMANT'S OWN SIGNATURE: B Mark Bay 611
ADDRESS: Burley Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock from hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Instantly

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Fractures L lower leg — " "

DUE TO (c) Rt. Skull fracture — " "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Brain injury

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06 13

21c. (CITY, TOWN, OR TOWNSHIP) Highway 16 (COUNTY) Cassia (STATE) Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Hit by auto while riding Honda

22. *I hereby certify that I attended the deceased from* 9-16, 1967, to 9-16, 1967 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 3:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M D

23b. ADDRESS: Burley Ida

23c. DATE SIGNED: 9-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 20, 1967

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery,

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Sept. 21, 1967

REGISTRAR'S SIGNATURE: Bill H. Pearson

25. EMBALMER: Vern B. McCulloch

LICENSE NO.: E-260

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4010
Local Reg. No. 1752
Reg. Dist. No. 470

RECEIVED SEP 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 16 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 160
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oakley
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Theodore	Jackson	Helms	Sept. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	April 10, 1881	86	5	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04	Farming	Christman, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Phillip Helms,	Indiana	Rosa Ward,	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	— — —	518-14-1426A	T. Austin Helms	Oakley Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myo Cardeal Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. uremia due to Nephro Sclerosis 5-4-m

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	none	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
none		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 195, 19—, *to* 9-18-, 1967, *that I last saw the deceased alive on* 9-11-1967, *and that death occurred at* 7:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R Sutton 514	md	Burley Idaho	9-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 22, 1967	Marion Cemetery	Marion, Cassia Co. Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 21 1967	Burt H. Pierson	Ormand Burch	E471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 2 6 1975

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4011
Local Reg. No. 1753
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 970

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middleton
d. STREET ADDRESS (If rural, give location): Box 64

3. NAME OF DECEASED (Type or Print)
a. (First): Ethel
b. (Middle): Elvira
c. (Last): Wanzer

4. DATE OF DEATH (Month) (Day) (Year): Sept. 26, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Oct. 29, 1890
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Slankard — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 445-07-4871
17. INFORMANT'S OWN SIGNATURE: Bryan E Wanzer — ADDRESS: Rupert, Ida.

332X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 24, 1967, *to* Sept 26, 1967, *that I last saw the deceased alive on* Sept 25, 1967, *and that death occurred at* 6:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Eugene [signature] 239 (Degree or title)
23b. ADDRESS: 1341 Overland Ave., Burley, Ida
23c. DATE SIGNED: 9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 9/26/67
24c. NAME OF CEMETERY OR CREMATORY: Middleton Cemetery
24d. LOCATION (City, town, or county) (State): Middleton, Idaho

DATE REC'D BY LOCAL REG.: Sept. 29, 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: [signature]
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4012
Local Reg. No. 1754
Reg. Dist. No. 470

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Cassia OCT 9 1967 161 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley Bureau of Vital Statistics
c. LENGTH OF (in this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Burley Nursing Home 290

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Adam
b. (Middle)
c. (Last) Zimmerman

4. DATE OF DEATH (Month) (Day) (Year) Sept 28 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 2
8. DATE OF BIRTH July 19 1887
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer-Farm 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Odessa South Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Pete Zimmerman — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Elizabeth Landschidle — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-05-6568
17. INFORMANT'S OWN SIGNATURE Esther Praegitzer — ADDRESS 424 - 1st St. Rupert Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

584X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Septicemia + bacteremia — INTERVAL BETWEEN ONSET AND DEATH 1 wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cholecystitis - — 2-3 yrs.
DUE TO (c) Cholelithiasis and obst.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/21, 1962, *to* 9/28, 1967, *that I last saw the deceased alive on* 9/28/67, 19___, *and that death occurred at* 6 02 *a. m., from the causes and on the date stated above.*

23a. SIGNATURE Robert M Stovall Jr MD 506 (Degree or title)
23b. ADDRESS Paul, Idaho
23c. DATE SIGNED 9/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 9-28-1967
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetry
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. Oct 3 1967
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER Charles H Persons
LICENSE NO. E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WALK MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4013
Local Reg. No. 75
Reg. Dist. No. 210

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe-rural
LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): own home 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 180
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weippe-rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Edward	A.	Lehr	Sept., 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 5	Feb. 26, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mill worker 16	lumber	Warren, Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John L. Lehr	Prussia	Wilhelmine Timm	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		391-18-7556	X Esther C Lehr	Weippe

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: few Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-24, 1967, *to* 9-10-67, 19___, *that I last saw the deceased alive on* 8-28, 1967, *and that death occurred at* 1:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A B Rappenhagen 405 M.D.	Orofino Idaho	9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9-14-67	Weippe Cemetery	Weippe Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 13, 1967	June M. Powell	Lyle A. Stratmann	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 26 1967

SEP 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4014
Local Reg. No. 76
Reg. Dist. No. 210

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Headquarters
c. LENGTH OF STAY (in this place): few min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Fork of Butte Creek

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon
b. COUNTY: Wallowa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallowa
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ELVIN	EUGENE	BERRY	Sept. 15 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	divorced	June 12, 1934	33				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Woodsworker	Timber	Wallowa Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Berry	Iowa	Ora Dell Prince	Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Korean	540-36-4289	Lyle A. Gilbertsen	Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Extensive skull fracture — INTERVAL BETWEEN ONSET AND DEATH: inst.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Logging accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Forest	Headquarters Clearwater Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒	NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Sept. 15 '67 11:15 a.m.			Struck by log while operating dozer

22. *I hereby certify that I attended the deceased from* never, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Larry Wunderlich 583	Coroner 4	Pierce, Idaho	Sept. 16 '67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Sept. 16 '67	Bollman Funeral Home	Enterprise Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 16 '67	Josephine L. Duff	Lyle A. Gilbertsen	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 4 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25. OCT 16 1967

DEC 10 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4015
Local Reg. No. 78
Reg. Dist. No. 210

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bungalow Ranger Station
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hall's Logging Camp 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 13 Idaho 180
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elk River
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Floyd
b. (Middle): Aderian
c. (Last): Duncan

4. DATE OF DEATH (Month) (Day) (Year): Sept. 19, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 15, 1915
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Dozer Operator 17
10b. KIND OF BUSINESS OR INDUSTRY: Logging
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leon Duncan — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Ethel M. Roland — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 712-07-9041
17. INFORMANT'S OWN SIGNATURE: x Agnes M Duncan — ADDRESS: Elk River

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): C. V. A. — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Bunk house
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Bungalow Ranger Station Clearwater Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9 19 67 1 A.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: Died in Sleep in bed

22. *I hereby certify that I attended the deceased from* never, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Larry D Wunderlich 583 Coroner 4
23b. ADDRESS: Ron Del Pierce Idaho
23c. DATE SIGNED: 9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY: Freeze Cemetery
24d. LOCATION (City, town, or county) (State): Near Potlatch Idaho

DATE REC'D BY LOCAL REG.: October 2, 1967
REGISTRAR'S SIGNATURE: June M. Powell
25. EMBALMER: Lyle A. Strottmann
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 17 2017 OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4016
Local Reg. No. 77
Reg. Dist. No. 210

BIRTH NO.

RECEIVED OCT 2 1967 Vital Statistics Bureau of H.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180 105
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
LENGTH OF STAY (in this place): 3 yr 7 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 440 b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 745 East Liberty

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EDNA		SKOW	Sept. 28 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	October 2, 1880	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07		Unknown	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unknown	519-20-0963	Caroline Blondel Records	Orofino, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4918

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Broncho pneumonia	2 months
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Chronic brain syndrome, arteriosclerosis	3 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept. 6, 19 67, to Sept. 28, 19 67, *that I last saw the deceased alive on* Sept. 28, 19 67, *and that death occurred at* 9:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M.D.	Box 672, Orofino, Idaho	Sept. 28, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Sept. 29, 1967	Northam-Jones FH	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 29, 1967	June M. Powell	Lyle A. Gilbertson	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4017
Local Reg. No. 6
Reg. Dist. No. 680

RECEIVED SEP 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Custer 190
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural-Mackay
LENGTH OF STAY (in this place): 00
d. FULL NAME OF HOSPITAL OR INSTITUTION: Copper Basin (58mi. W.Mackay)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 190 b. COUNTY: Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mackay
d. STREET ADDRESS (If rural, give location): Smelter Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NEETCH	ARMITAGE	LARTER	September 6,1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Oct. 20,1902	64				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Cattle Ranch	Barton Flat, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry T. Larter	Moroni, Utah	Christina Jensen	Mt. Pleasant,Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-12-6919	X Nate Larter	Mackay, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease 6 yrs.
DUE TO (c) Arteriosclerotic Heart Disease 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1950, 19[illegible] *to* [illegible] 1967, *that I last saw the deceased alive on* 9-3, 1967 *and that death occurred at* 6:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
R J Rankin MD	Arco, Idaho	9-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-9-67	Mt. McCaleb	Mackay, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-13-67	Mrs Pauline J. Mulder	C. H. Marvel	E-457

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 24 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4018
Local Reg. No. 7
Reg. Dist. No. 680

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Custer 190 OCT 9 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township place): Rural-Challis
c. LENGTH OF STAY (If outside corporate limits, write RURAL and give township place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4.5 Mi. West of Challis

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 190
b. COUNTY: Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Travers
b. (Middle): Hamblin 000
c. (Last): Warren

4. DATE OF DEATH (Month) (Day) (Year): September 29, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 8, 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): County Assessor 08
10b. KIND OF BUSINESS OR INDUSTRY: County Official
11. BIRTHPLACE (State or foreign country): Butte, Montana
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Wm Henry Warren Eganville, Ontario, Canada
14. MOTHER'S MAIDEN NAME: Edith Catherine McKonkey Kentville, Ont. Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-34-9636
17. INFORMANT'S OWN SIGNATURE: X Minnie B. Warren — ADDRESS: Challis, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Self-inflicted gunshot wounds in upper left thoracic region and

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) anterior right skull

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH: Instant

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 2 Suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 00
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 000
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased* As Coroner Only *, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at* 6:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 583 Glen W. Reed Custer Co. Coroner
23b. ADDRESS: Challis, Idaho
23c. DATE SIGNED: 10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-5-67
24c. NAME OF CEMETERY OR CREMATORY: Mt. McCaleb Cemetery
24d. LOCATION (City, town, or county) (State): Mackay, Idaho

DATE REC'D BY LOCAL REG.: 10-5-67
REGISTRAR'S SIGNATURE: Pauline J. Mulder
25. EMBALMER: E. H. Marvel
LICENSE NO.: E-457

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4019
Local Reg. No. 8
Reg. Dist. No. 680

RECEIVED OCT 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Custer
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mackay
c. LENGTH OF STAY IN (this place): 32 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elm Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mackay
d. STREET ADDRESS (If rural, give location): Elm Avenue

3. NAME OF DECEASED (Type or Print): a. (First) SARAH b. (Middle) ALICE c. (Last) BITTON

4. DATE OF DEATH (Month) (Day) (Year): Sept. 29, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Feb. 28, 1889

9. AGE (In years last birthday): 78
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Richfield, Utah

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Hans Peterson — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Sarah Alice Higgins — BIRTHPLACE: Richfield, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-30-6838B

17. INFORMANT'S OWN SIGNATURE: X W. H. Bitton — ADDRESS: Mackay, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 Yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis Generalized — 10 yrs
~~DUE TO (c)~~

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Cerebral Vascular Accident — 12 yr.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967 *to* Sept, 1967, *that I last saw the deceased alive on* Sept 29, 1967, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. Barker M.D. (Degree or title)

23b. ADDRESS: Arco, Idaho

23c. DATE SIGNED: 10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-3-67

24c. NAME OF CEMETERY OR CREMATORY: Mt. McCaleb Cemetery

24d. LOCATION (City, town, or county) (State): Mackay, Idaho

DATE REC'D BY LOCAL REG.: 10-9-67

REGISTRAR'S SIGNATURE: Mrs. Hawkins Jo Mulder

25. EMBALMER: C. H. Marvel — LICENSE NO.: E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 18 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. OCT 24 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 30 1981

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4020
Local Reg. No. 63
Reg. Dist. No. 380 391

RECEIVED SEP 21 1967

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 200
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glenns Ferry
d. STREET ADDRESS (If rural, give location) Glenns Ferry

3. NAME OF DECEASED (Type or Print)
a. (First) DAVID
b. (Middle) WASHINGTON
c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year) Sept. 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 6, 1880
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 10 Retired - Engineer
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Menden, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Michael J. Smith — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Hibler — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Donald O. Smith — ADDRESS Mt. Home

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5702

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Mesenteric thrombosis — INTERVAL BETWEEN ONSET AND DEATH hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. A.S.H.D., Chronic brain Syd. — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 5, 1967, *to* Sept. 7, 1967, *that I last saw the deceased alive on* Sept. 6, 1967, *and that death occurred at* 3:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Malone W. Deloach M.D. 289 (Degree or title)
23b. ADDRESS Mountain Home Idaho
23c. DATE SIGNED Sept. 15/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/9/67
24c. NAME OF CEMETERY OR CREMATORY Glenn Rest Cemetery
24d. LOCATION (City, town, or county) (State) Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG. Sept 18 1967
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Arthur Smith
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 19 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 21 1967

Certificate of Death

STATE OF IDAHO

State File No. 4021
Local Reg. No. 64
Reg. Dist. No. 380 391

BIRTH NO. Amended 7-27-78

1. PLACE OF DEATH
a. COUNTY: Elmore 200 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mtn. Home Air Force Base
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Air Foece Hsopital 076

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 200
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 125 East 12th North

3. NAME OF DECEASED (Type or Print)
a. (First): AUGUSTUS
b. (Middle): DOW
c. (Last): STOKESBERRY

4. DATE OF DEATH (Month) (Day) (Year): Sept. 7, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 24, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 06 Steam Plant Operator
10b. KIND OF BUSINESS OR INDUSTRY: Heating
11. BIRTHPLACE (State or foreign country): Otero County, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: A. N. Stokesberry — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Annie Marie — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 523-22-1696
17. INFORMANT'S OWN SIGNATURE: William A. Stokesberry — ADDRESS: Boise

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Artery Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive - investigation only *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 10:51 PM *from the causes and on the date stated above.*

23a. SIGNATURE 583 Arthur Smith (Degree or title): Coroner 4
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 9/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/12/67
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Sept 18 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Verl Humphrey
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

SEP 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

SEP 01 2000

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
BUREAU OF
VITAL STATISTICS
JUL 27 12 14 PM '78

State of ..... } ss.
County of ..... }

Certificate No. D67-4021

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for August Dow Stokesberry (Name on Original Certificate) who died (Was Born or Died) on Sept. 7, 1967 (Date of Event)
in Elmore County (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
first name of deceased	August	Augustus

Subscribed and sworn to before me this 26th day of July, 19 78

Florence Partridge

Notary Public, residing at Boise

My commission expires September

(Seal)

Signed Patricia June
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

.....
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of ..... } ss.
County of ..... }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this ..... day of
....., 19.....

.....

Notary Public, residing at .....

My commission expires .....
(Seal)

Signed .....
(Signature of Any Credible Person)

.....
(Street Address, City, State)

FORM DH 60-155

In office 7-26-78 no corresp. fc

Own child's birth certifiate on file with Bureau of Vital Statistics gives name as Augustus D. Stokesberry, father of child. Child born Feb. 22, 1952 , state file # 52-1241
Viewed by V.S.

JUL 2 7 1978

State of Colorado Bureau of Vital Statistics has record of birth for Augustus Dow Stokesberry born Auguts 24, 1901 in Otero County, Colorado. # 61 Dist. 164.
Viewed by V.S.

State File No. 4022
Local Reg. No. 65
Reg. Dist. No. 380391

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 200
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 200
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Mountain Home
d. STREET ADDRESS (If rural, give location): Aguirre Road Rt. # 1 Box 834

3. NAME OF DECEASED (Type or Print)
a. (First): JUAN
b. (Middle): CASTOR
c. (Last): BILBAO

4. DATE OF DEATH (Month) (Day) (Year): Sept. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: March 5, 1900
9. AGE (In years last birthday): 67 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 04 Retired - Sheepherder
10b. KIND OF BUSINESS OR INDUSTRY: Sheep
11. BIRTHPLACE (State or foreign country): Izpaster, Viscaya, Spain
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Tomas Lete — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Antonia Laucirica — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 726-16-6994
17. INFORMANT'S OWN SIGNATURE: Jimmie Aguirre — ADDRESS: Mtn. Home, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sep 9, 1967, *to* Sept. 10, 1967, *that I last saw the deceased alive on* Sept. 10, 1967, *and that death occurred at* 4:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Malone W. Loesch 289 MD
23b. ADDRESS: Mountain Home Idaho
23c. DATE SIGNED: Sept. 15, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/13/67
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Sept 18 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Verl Humphrey
LICENSE NO.: E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4023
Local Reg. No. 66
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY IN THIS PLACE: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mountain Home Hotel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 200
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): Mountain Home Hotel #205

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MRS.	JUNNE	ILEENE CROWLEY	Sept. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	June 30, 1925	42				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Springfield, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
M. D. Pownell	Missouri	Mavel Royster	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-22-2758	Charles R Crowley Sr	Mt. Home

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Strangulation by hanging
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide	hotel room	Mountain Home, Elmore, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
Sept. 20, 1967		Used belt from bath robe, hung from transom.

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation only *saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur S Smith Coroner	Mountain Home, Idaho	9/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/25/67	Mountain View Cemetery	Mountain Home, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 27 1967	[signature]	H Verl Humphreys	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 26 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP - 9 1994

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-8970 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4024
Local Reg. No. 67
Reg. Dist. No. 380 391

BIRTH NO.

OCT 23 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt Home AFB
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 67 Tac Hosp Mt Home AFB Ida

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 200
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt Home AFB
d. STREET ADDRESS (If rural, give location): 4331D Mtn Village

3. NAME OF DECEASED (Type or Print)
a. (First): SUTTON
b. (Middle): DENISE
c. (Last): ROBERSON

4. DATE OF DEATH (Month) (Day) (Year): Sep 28 1967

5. SEX: Female
6. COLOR OR RACE: Cau
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 17 Sep 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 11; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mt Home AFB Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Jeri C. Roberson
BIRTHPLACE: Kewanee, Illinois
14. MOTHER'S MAIDEN NAME: Polly J. Brown
BIRTHPLACE: Oklahoma City, Okla

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Official Medical Records
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7545

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congenital Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 28 Sep, 1967, *to* 28 Sep, 1967, *that I last saw the deceased alive on* 28 Sep, 1967, *and that death occurred at* 1000 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Barry S. Russman
BARRY S. RUSSMAN, CAPT, USAF, MC 585 MD
23b. ADDRESS: 67 Tac Hosp Mt Home AFB Ida
23c. DATE SIGNED: 28 Sep 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/30/67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Oct 17 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: H. Neal Humphrey
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4025
Local Reg. No. 17
Reg. Dist. No. 540

BIRTH NO.

RECEIVED OCT 3 1967 Vital Statistics Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Franklin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fairview
c. LENGTH OF STAY (In this place) 30 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 8th South 4th West

3. NAME OF DECEASED (Type or Print) a. (First) Orval b. (Middle) Joseph c. (Last) Smith

4. DATE OF DEATH (Month) Sept. (Day) 25 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Dec. 28, 1906

9. AGE (In years last birthday) 60 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milk Hauler

10b. KIND OF BUSINESS OR INDUSTRY Sego Milk Co.

11. BIRTHPLACE (State or foreign country) Fairview, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Joseph Smith BIRTHPLACE Richmond, Utah

14. MOTHER'S MAIDEN NAME Nellie Gilbert BIRTHPLACE Richmond, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 09 0045

17. INFORMANT'S OWN SIGNATURE Deatha M. Smith ADDRESS Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Truck Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) County road

21c. (CITY, TOWN, OR TOWNSHIP) Preston 211 (COUNTY) Franklin (STATE) Ida ho

21d. TIME OF INJURY (Month) Sept. (Day) 25-67 (Year) (Hour) 9a m.

21e. INJURY OCCURRED WHILE AT WORK ☑ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Truck accident

22. I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 9 a m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)

23b. ADDRESS Preston Idaho

23c. DATE SIGNED 9-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY Preston

24d. LOCATION (City, town, or county) Preston (State) Idaho

DATE REC'D BY LOCAL REG. 9-28-67

REGISTRAR'S SIGNATURE Eppie W. Brower

25. EMBALMER Warren Webb

LICENSE NO. 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit-ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 17 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4026
Local Reg. No. 19
Reg. Dist. No. 340

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 211 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 95 West 8th south 100

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 555
b. COUNTY: Iron County
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cedar City
d. STREET ADDRESS (If rural, give location): Box 14

3. NAME OF DECEASED (Type or Print): a. (First) Alpheus b. (Middle) c. (Last) Smith

4. DATE OF DEATH: (Month) Sept. (Day) 27 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	Feb. 4, 1908	59		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cleveland, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: George Albert Smith — BIRTHPLACE: Banida, Idaho
14. MOTHER'S MAIDEN NAME: Hannah M. Nielsen — BIRTHPLACE: Cleveland, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War II 4
16. SOCIAL SECURITY NO.: 528 20 7176
17. INFORMANT'S OWN SIGNATURE: Amanda Pace — ADDRESS: Cedar City Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cor pulmonale

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/26, 1967, *to* _____, 19___, *that I last saw the deceased alive on* 9/26 19 67, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leo K. Hawkes M.D 214
23b. ADDRESS: Preston, Ida
23c. DATE SIGNED: 9/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: 9-30-67
REGISTRAR'S SIGNATURE: Eyre W. Brower
25. EMBALMER: O. Sherwin Webb
LICENSE NO.: 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 31 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4027
Local Reg. No. 18
Reg. Dist. No. 340

RECEIVED OCT 17 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial Hospital 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 211
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 138 N. State Street

3. NAME OF DECEASED (Type or Print): a. (First) Harry b. (Middle) M. c. (Last) Wittner

4. DATE OF DEATH (Month) (Day) (Year): Sept. 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	white	widdowed 2	Dec 10, 1889	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): bar tender 23
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): South Bend, Indiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Oliver Wittner — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Catherine Moyer — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 528-16-0645 A
17. INFORMANT'S OWN SIGNATURE: Glenn C Thornley ADDRESS (Street, City, State): Preston Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 7 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July 1, 1967 *to* Sept 27, 1967, *that I last saw the deceased alive on* Sept 27, 1967, *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. R. Cutler M.D.	Preston Idaho	9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 30, 1967	Franklin Cemetery	Franklin, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-30-67	Effie W. Brower	Douglas S. Webb	488

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-9008 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4028
Local Reg. No. 53
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont SEP 11 1967
b. CITY OR TOWN Ashton Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 220 b. COUNTY Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DAVID	SHANE	BRIGGS	Sept., 1, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Sept., 1, 1967.				7	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02		Ashton, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Albert Briggs., Jr.	Rexburg, Ida	Sandra Lee Reed	Washington, D. C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	None	George A. Briggs Jr.	St. Anthony, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Newborn, Premature, 23 week gestation. — INTERVAL BETWEEN ONSET AND DEATH: 6 hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1 Sept., 1967, *to* 1 Sept., 1967, *that I last saw the deceased alive on* 1 Sept., 1967, *and that death occurred at* 12:45P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. A. Melchin MD	Ashton, Idaho	6 Sept. 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	5 Sept 67	Teton-Newdale Cemetery	Sugar City, RFD#1, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
7 Sept 67	N. L. Hansen	N. L. Hansen	E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4029
Local Reg. No. 57
Reg. Dist. No. 650

Certificate of Death

STATE OF IDAHO

BIRTH NO. 67-9009

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 221
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): BRYAN
b. (Middle): R.
c. (Last): NEDROW

4. DATE OF DEATH (Month) (Day) (Year): Sept., 5, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Sept., 5, 1967
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 0, Days 0 — IF UNDER 24 HRS.: Hours 5, Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: J. Richard Nedrow — BIRTHPLACE: St. Anthony, Idaho
14. MOTHER'S MAIDEN NAME: Mary Baker — BIRTHPLACE: Rexburg, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No.
17. INFORMANT'S OWN SIGNATURE: J. Richard Nedrow — ADDRESS: Ashton, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anterepiratory distress — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) prematurity
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept 5, 1967, *to* Sept 5, 1967, *that I last saw the deceased alive on* Sept 5, 1967, *and that death occurred at* 8 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lloyd Barratt M.D. 030
23b. ADDRESS: St. Anthony
23c. DATE SIGNED: 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8 Sept 67
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 9-20-67
REGISTRAR'S SIGNATURE: M. D. Hansen
25. EMBALMER: M. D. Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4030
Local Reg. No. 58
Reg. Dist. No. 651

RECEIVED OCT 4 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place): 180
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 220
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): 8 Miles East of Ashton

3. NAME OF DECEASED (Type or Print)
a. (First): ZINA
b. (Middle): IOWA GUNTER
c. (Last): HOWELL

4. DATE OF DEATH (Month) (Day) (Year): Sept. 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 24 October 1887
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Dillsboro, North Carolina
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Alexander Gunter — BIRTHPLACE: Jackson Co., N.C.
14. MOTHER'S MAIDEN NAME: Sarah Jane York — BIRTHPLACE: Cherokee Co., N.C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): -------
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Arteriosclerotic heart disease — 2 years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-4, 1967, *to* 9-7-, 1967, *that I last saw the deceased alive on* 9-7-, 1967, *and that death occurred at* 4:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 298
23b. ADDRESS: Ashton, Idaho
23c. DATE SIGNED: 9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE:
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 29 Sept 67
REGISTRAR'S SIGNATURE: M. L. Hansen
25. EMBALMER: Robert A. Bean — LICENSE NO. E456

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bean Funeral Home

DUTIES:

JUN 5 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4031
Local Reg. No. 59
Reg. Dist. No. 651

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ora
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): His Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 220
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ora
d. STREET ADDRESS (If rural, give location): 5 Miles West of Ashton

3. NAME OF DECEASED (Type or Print)
a. (First): FREDRICK
b. (Middle): CHARLES
c. (Last): PORTER

4. DATE OF DEATH (Month) (Day) (Year): September 11, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 21 November 1879
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Oxford, New Zealand
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Arthur Porter, Sr. — BIRTHPLACE: Essex Co., England
14. MOTHER'S MAIDEN NAME: Louise Marie Kobel — BIRTHPLACE: Australia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 519-40-4286
17. INFORMANT'S OWN SIGNATURE: x Mrs Erma Hess — ADDRESS: Ashton, Idaho

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-9-, 1967, *to* 9-11-, 1967, *that I last saw the deceased alive on* 9-9-, 1967, *and that death occurred at* 5:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 298
23b. ADDRESS: Ashton, Idaho
23c. DATE SIGNED: 9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 14 Sept. 67
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.: 29 Sept 67
REGISTRAR'S SIGNATURE: M L Hansen
25. EMBALMER: Robert A. Dean — LICENSE NO.: E 456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 14 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4032
Local Reg. No. 56
Reg. Dist. No. 651

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: FREMONT
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Teton City,
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Teton City
d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALBERT	HEATON	SEARLE	Sept., 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married	30 Sept 1892	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic- Auto	Retired	Payson, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert B. Searle	Payson, Utah	Selina Heaton	Payson, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	518-09-8587	Quine L. Searle	Ammon, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Miocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* DOA, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul Lowell 583	Coroner	Po. Box 123. St. Anthony, Ida.	9-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	16 Sept. 67	Teton-Newdale Cemetery	Sugar City Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
20 Sept 67	M L Hansen	M L Hansen	E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Sept. 22, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4033
Local Reg. No. 55
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Macks Inn
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1½ mile East on Snake River

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 03 Arizona
b. COUNTY Maricopa 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Phoenix
d. STREET ADDRESS (If rural, give location) 5250 North 20th Street

3. NAME OF DECEASED (Type or Print) a. (First) Raymond (aka Jack) b. (Middle) M. c. (Last) Tenney
4. DATE OF DEATH (Month) (Day) (Year) Sept. 12, 1967

5. SEX Male
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 12, 1902
9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 06 Consultant (retired)
10b. KIND OF BUSINESS OR INDUSTRY Refrigeration
11. BIRTHPLACE (State or foreign country) Centralia, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Justin Tenney BIRTHPLACE Wisconsin
14. MOTHER'S MAIDEN NAME Gertrude Mathias BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. ?
17. INFORMANT'S OWN SIGNATURE Jewel W. Tenney, ADDRESS Phoenix, Arizona

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION (by telephone)

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE Paul Romell, 583 Coroner (Degree or title)
23b. ADDRESS St. Anthony, Idaho
23c. DATE SIGNED 13 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 13 Sept 67
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Phoenix, Maricopa County, Ariz.

DATE REC'D BY LOCAL REG. 13 Sept 67
REGISTRAR'S SIGNATURE M. D. Hansen
25. EMBALMER M. D. Hansen
LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Arizona } ss.
County of Maricopa }

RECEIVED
SEP 22 1967
Bureau of Vital Statistics

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Jack M. Tenney (Name on Original Certificate) died (Was Born or Died) on Sept 12, 1967 (Date of Event)
in Macks Inn, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name of Deceased	Jack M. Tenney	Raymond (aka Jack) M. Tenney

Subscribed and sworn to before me this 20 day of September, 19 67

Margaret E. Tolley

Notary Public, residing at Phoenix, Arizona

My commission expires My Commission Expires July 11, 1970
(Seal)

Signed Jewel M. Tenney
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

5250 N. 20th St., Phoenix, Arizona
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Arizona } ss.
County of Maricopa }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 20 day of September, 19 67

Margaret E. Tolley

Notary Public, residing at Phoenix, Arizona

My commission expires My Commission Expires July 11, 1970
(Seal)

Signed Richard C. Maurer
(Signature of Any Credible Person)

1541 E. Thomas Rd., Phoenix, Arizona
(Street Address, City, State)

FORM DH 60-155

9-18-67 RP

Jack N. Tenney

Sept 15, 1967

Name of Deceased: Jack N. Tenney

Raymond (aka Jack) N. Tenney

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 55
Reg. Dist. No. 65 1

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Macks Inn
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1½ mile East on Snake River

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Arizona
b. COUNTY: Maricopa
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Phoenix
d. STREET ADDRESS (If rural, give location): 5250 North 20th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JACK	M.	TENNEY	Sept., 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married	July 12, 1902	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Consultant (retired)	Regrieration	Centralia, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Justin Tenney	Wisconsin	Gertrude Mathias	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	?	Jewel W. Tenney	Phoenix, Arizona

MEDICAL CERTIFICATION (by Telephone)

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl Tomlin Coroner	St. Anthony, Idaho	13 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	13 Sept 67		Phoenix, Maricopa County, Ariz.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
13 Sept 67	M. L. Hansen	M. L. Hansen	E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4034
Local Reg. No. 60
Reg. Dist. No. 651

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
LENGTH OF STAY (in this place): 220
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 183

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 220
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): None Given

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): FRIEDA ELIZABETH KANDLER HARRINGFELD

4. DATE OF DEATH (Month) (Day) (Year): Sept. 16, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 24 November 1893

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: ------

11. BIRTHPLACE (State or foreign country): Woldegk, Germany

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis Kandler
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Fredericke Peters
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 518-44-8970

17. INFORMANT'S OWN SIGNATURE: William E. Harringfeld Jr
ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 8 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary thrombosis — 9 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-9-, 1967, *to* 9-16-, 1967, *that I last saw the deceased alive on* 9-16-, 1967, *and that death occurred at* 2:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 298 — **23b. ADDRESS**: Ashton Idaho — **23c. DATE SIGNED**: 9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 18 Sept. 67
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.: 29 Sept 67
REGISTRAR'S SIGNATURE: M. L. Hansen

25. EMBALMER: Robert Q. Bean
LICENSE NO.: E-456
FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 12 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4035
Local Reg. No. 61
Reg. Dist. No. 651

RECEIVED OCT 17 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): 8 mi. North of Ashton
c. LENGTH OF STAY (In this place): XXXX 10D
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bishop Mountain north of Ashton

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tetonia
d. STREET ADDRESS (If rural, give location): none - rural area

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	KEITH	MARLER	POULSON	Sept. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	Married 3	July 14, 1910	57				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer-Laborer 04	Timber	Clawson, Teton Co., Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Christian Poulson	unknown	Joan Marler	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 2		X Shirley A. Poulsen	Tetonia, Ida
Yes	WW2 9708			

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Fractured Skull — INTERVAL BETWEEN ONSET AND DEATH: instent

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Tree accident

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident 04	timber land 13	220 Fremont County, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Sept. 20, 1967 m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	tree fell-striking on right shoulder and hea

22. *I hereby certify that I attended the deceased from* D.O.A. *, 19__, to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at* 11:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul Romrell 583	coroner	P.O.Box 123 St. Anthony, Idaho	9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	9/23/67	Cache-Clawson Cemetery	Teton Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
5 Oct 1967	M. Hansen	Robert Bean	E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH:

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

OCT 19 1967

Bureau of Vital Statistics

State File No. 4036
Local Reg. No. 63
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give): Ashton
c. LENGTH OF STAY (in this place): 110
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): None Given

3. NAME OF DECEASED (Type or Print): a. (First) SIMON; b. (Middle) ALBERT; c. (Last) NEDROW

4. DATE OF DEATH: September 28, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: January 7, 1880

9. AGE (In years last birthday): 87 — If under 1 year: Months 8, Days 21; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - Rancher

10b. KIND OF BUSINESS OR INDUSTRY: Farm - Ranch

11. BIRTHPLACE (State or foreign country): Abilene, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Simington Nedrow — BIRTHPLACE: Canal Dover, Ohio

14. MOTHER'S MAIDEN NAME: Sarah Riddle — BIRTHPLACE: LaSalles, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------

16. SOCIAL SECURITY NO.: 518-42-9556

17. INFORMANT'S OWN SIGNATURE: Mabel Nedrow — ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Hodgkin's disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Congestive heart failure — 6 mos.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct, 1966, *to* Sept 28, 1967, *that I last saw the deceased alive on* Sept 28, 1967, *and that death occurred at* 5P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): 298

23b. ADDRESS: Ashton, Idaho

23c. DATE SIGNED: 10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 30 Sept. 67

24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery

24d. LOCATION (City, town, or county) (State): Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 17 Oct 67

REGISTRAR'S SIGNATURE: M. L. Hansen

25. EMBALMER: Robert O. Bean — LICENSE NO.: E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JUN 18 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES; Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED SEP 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4037
Local Reg. No. 16
Reg. Dist. No. 340 341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 237 313
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 231
b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Box 108 Emmett Valley Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Joshua	Franklin	Hartley	Sept. 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed 2	May 21, 1883	84	3	11		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farm	Bountiful, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hyrum Hartley	England	Weltha Hatch	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 12 7306	X Lela A. Markham	44727 10th W. Lancaster, Cal.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vasc. accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes Mellitus
DUE TO (c) Gen Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan 1961 *to* Sept 1967, *that I last saw the deceased alive on* Sept 2, 1967, *and that death occurred at* 9:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B Jewell MD	107 N. Comm., Emmett, Ida	9-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 5, 1967	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 11, 1967	Jean G Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4038
Local Reg. No. 14
Reg. Dist. No. 340-341

RECEIVED SEP 15 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 23 1/5 118
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
LENGTH OF STAY (in this place): 18 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mounted Route 122

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 23 b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Mounted Route

3. NAME OF DECEASED (Type or Print): a. (First) Ernest b. (Middle) Bren c. (Last) Butler

4. DATE OF DEATH (Month) (Day) (Year): Sept. 4, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Feb. 25, 1902

9. AGE (In years last birthday): 65 IF UNDER 1 YEAR Months: 6 Days: 9 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 17 machine operator

10b. KIND OF BUSINESS OR INDUSTRY: lumber

11. BIRTHPLACE (State or foreign country): Chester, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Neri Butler BIRTHPLACE: Butlerville, Utah

14. MOTHER'S MAIDEN NAME: Ora Garrett BIRTHPLACE: Oxford, Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 07 3577

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: X Mary D. Butler 15192 Coronado Westminster Calif

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) gun shot in head — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 2 Suicide

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 01 home 13

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Emmett 23 Gem Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 4, 1967 unknown

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Shot self in temple (right side)

22. *I hereby certify that I attended the deceased from* never *19____, to* between 1 Am & 3 AM *19____, that I last saw the deceased alive on _____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Glenn W Beatty 583 (Degree or title): coroner Gem County

23b. ADDRESS: Emmett, Idaho

23c. DATE SIGNED: Sept. 5, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Sept. 6, 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Sept 6, 1967

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 26 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4039
Local Reg. No. 15
Reg. Dist. No. 340-341

Certificate of Death

RECEIVED
SEP 15 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 3 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shady Lane Nursing Home 265

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 230
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sweet
d. STREET ADDRESS (If rural, give location): Box 54

3. NAME OF DECEASED (Type or Print)
a. (First): Amos
b. (Middle): Giles
c. (Last): Woods

4. DATE OF DEATH (Month) (Day) (Year): Sept. 5, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Nov. 6, 1890
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months 9, Days 29 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: farm
11. BIRTHPLACE (State or foreign country): Peola, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joe Woods — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Ann Shelton — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-03-1148
17. INFORMANT'S OWN SIGNATURE: X Amos E Woods — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) TERMINAL PNEUMONITIS — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) GENERAL DEBILITY
DUE TO (c) SEVERE ARTERIOSCLEROTIC HEART DISEAS — YEARS

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Sept. 5, 1967, *that I last saw the deceased alive on* Aug 29, 1967, *and that death occurred at* 8:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ronald P. Rawlinson MD
23b. ADDRESS: Emmett Ida
23c. DATE SIGNED: 9/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sweet
24d. LOCATION (City, town, or county) (State): Sweet, Idaho

DATE REC'D BY LOCAL REG.: Sept. 13 1967
REGISTRAR'S SIGNATURE: Jean A Beatty
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4040
Local Reg. No. 18
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 23 SEP 26 1967 10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 200
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mounted Route 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 23 b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Mounted Route

3. NAME OF DECEASED (Type or Print): a. (First) Ernest b. (Middle) Albert c. (Last) Hellyer

4. DATE OF DEATH (Month) (Day) (Year): September 8, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: June 10, 1897

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 70

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Greelee, Colorado

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Hellyer — BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Dell Sellers — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 522 14 0610

17. INFORMANT'S OWN SIGNATURE ADDRESS: X Jennie Hellyer

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of lip & metastases — INTERVAL BETWEEN ONSET AND DEATH: 10 mons

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) None

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

1409

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1966, *to* May, 1967, *that I last saw the deceased alive on* May 19, 1967, *and that death occurred at* 8:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm B. Jewell 260 MD

23b. ADDRESS: 107 N. Comm., Emmett, Ida

23c. DATE SIGNED: 9-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Sept. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Sept. 15, 1967

REGISTRAR'S SIGNATURE: Glenn A Beatty

25. EMBALMER: Glenn W Beatty — LICENSE NO.: E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4041
Local Reg. No. 17
Reg. Dist. No. 340-341

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 15 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place): DOA 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hosp. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 231
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Frank
b. (Middle): Weston
c. (Last): Wills

4. DATE OF DEATH (Month) (Day) (Year): Sept. 11, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: August 22, 1899
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Fruit
11. BIRTHPLACE (State or foreign country): Sheridian, Wyoming
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James A. Wills — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Ruth Olive Pool — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 09 7239
17. INFORMANT'S OWN SIGNATURE: X Cecilia K. Wills — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Probable Acute — Immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Myocardial infarction
DUE TO (c): Patient dead on arrival

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Intermittent chronic Auricular fibrillation — years

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1946, *to* Sept 11, 1967, *that I last saw the deceased alive on* July, 1967, *and that death occurred at* before 7 p.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ronald P. Rawlinson / MD
23b. ADDRESS: Emmett Ida
23c. DATE SIGNED: 9/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Sept. 13, 1967
REGISTRAR'S SIGNATURE: Jean A. Beatty
25. EMBALMER: Henry W. Beatty
LICENSE NO.: E392

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: The Beatty Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4042
Local Reg. No. 14
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED SEP 28 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 23 1 116
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
LENGTH OF STAY (in this place): 16 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 1, Box 6

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 23 1
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Rt. 1, Box 6

3. NAME OF DECEASED (Type or Print): a. (First) Thelma; b. (Middle) Lee; c. (Last) Fackler

4. DATE OF DEATH (Month) (Day) (Year): Sept 13, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: March 23, 1903

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Pearl, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George A. Sprague
BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Alice May Foster
BIRTHPLACE: Marietta, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-60-9028

17. INFORMANT'S OWN SIGNATURE: Ray L. Fackler
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vas Accident 331X
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* April, 1957, *to* Sept, 1967, *that I last saw the deceased alive on* Sept 8, 1967, *and that death occurred at* 5:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wm B Jewell MD 260 (Degree or title)
23b. ADDRESS: 107 N. Comm., Emmett, Idaho
23c. DATE SIGNED: 9-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Sept 26, 1967
REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 26 2006

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4043
Local Reg. No. 20
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 231 OCT 9 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 60 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA W.K.Mem. Hosp. 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 231
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Box 31, Rt. 1

3. NAME OF DECEASED (Type or Print): a. (First) Carl; b. (Middle) Preston; c. (Last) Watson

4. DATE OF DEATH (Month) (Day) (Year): Sept. 16, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Dec. 9, 1916

9. AGE (In years last birthday): 50 | IF UNDER 1 YEAR Months: 9 Days: 3 | IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 09 sales representative

10b. KIND OF BUSINESS OR INDUSTRY: power co.

11. BIRTHPLACE (State or foreign country): Wheatland, Wyo.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert H. Watson — BIRTHPLACE: Marion Co., Ill.

14. MOTHER'S MAIDEN NAME: Liza M. Davis — BIRTHPLACE: Marion Co., Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WWII

16. SOCIAL SECURITY NO.: 518-16-0548

17. INFORMANT'S OWN SIGNATURE: X Larry E. Watson — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept, 1967, *to* Sept, 1967, *that I last saw the deceased alive on* Sept, 1967 *and that death occurred at* 12:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D. — **23b. ADDRESS**: 1024 E Locust, Emmett — **23c. DATE SIGNED**: 9-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial — **24b. DATE**: Sept 19, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Dry Creek — **24d. LOCATION** (City, town, or county) (State): Ada Co., Idaho

DATE REC'D BY LOCAL REG.: Sept. 30, 1967 — REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty — LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL — Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4044
Local Reg. No. 21
Reg. Dist. No. 340-341

RECEIVED OCT 9 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 1day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 231
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 405 No. Washington

3. NAME OF DECEASED (Type or Print)
a. (First): Edith
b. (Middle): Elizabeth
c. (Last): Nichols

4. DATE OF DEATH (Month) (Day) (Year): Sept. 17, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Jan. 15, 1910
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Schickley, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lewis J. Barnum — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Fannie Elizabeth Neider — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 506-26-6135
17. INFORMANT'S OWN SIGNATURE: X Audrey M. Smith — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Contusions — INTERVAL BETWEEN ONSET AND DEATH: 18 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Compression of chest wall
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE XX (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06 Highway 16 13
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Emmett 231 Gem Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9-16-67 4:30pm
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Thrown forward on dash board

22. *I hereby certify that I attended the deceased from* Sept 16, 1967, *to* Sept 17, 1969, *that I last saw the deceased alive on* Sept 17, 1967, *and that death occurred at* 4:15 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm B. Jewell MD 260
23b. ADDRESS: 1024 E Locust, Emmett
23c. DATE SIGNED: 10-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Oct. 2, 1967
REGISTRAR'S SIGNATURE: Jean A Beatty
25. EMBALMER: Glenn W Beatty — LICENSE NO. E392

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: The Beatty Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 14 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4045
Local Reg. No. 22
Reg. Dist. No. 340-341

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): DOA 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Mem. Hosp. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 231
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Walter
c. (Last): White

4. DATE OF DEATH (Month) (Day) (Year): Sept. 28, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: June 22, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): maintenance foreman 08
10b. KIND OF BUSINESS OR INDUSTRY: Bur. of Reclamation
11. BIRTHPLACE (State or foreign country): Pender, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Laffayette A. White — BIRTHPLACE: Harlon, Iowa
14. MOTHER'S MAIDEN NAME: Elizabeth Jane Cary — BIRTHPLACE: Adrian, Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI 3
16. SOCIAL SECURITY NO.: 519-42-5897
17. INFORMANT'S OWN SIGNATURE: X Marie B White — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphixiation following — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Severe attack of status ~~Asthmaticus~~ due
DUE TO (c) Chronic Bronchial Asthma — 5 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Severe pulmonary fibrosis.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1946, to Sept 28, 1967, that I last saw the deceased alive on Sept 26, 1967, and that death occurred at 11:30 p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ronald P. Lawrence MD 429
23b. ADDRESS: Emmett Idaho
23c. DATE SIGNED: 4/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Oct. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE: Jean A. Beatty
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 16 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 18 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 27 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

DEC 18 1967

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

M. V. Kleiglen

Certificate of Death

STATE OF IDAHO

State File No. 4046
Local Reg. No. 2994
Reg. Dist. No. 420

BIRTH NO.

RECEIVED SEP 14 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hosp 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 634 8th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Ralph	Benjamin	Fletcher	Sept.	6,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 6, 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Merchant	Retired	Galesburg, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Fletcher	New Hampshire, Va.	Henrietta S. Brown	Galesburg, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-20-8404	Mrs. Thompson	Chapel Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease with Failure. — INTERVAL BETWEEN ONSET AND DEATH: 1 week.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertension, arteriosclerotic.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August 30, 1967, *to* Sept 6, 1967, *that I last saw the deceased alive on* Sept 5, 1967, *and that death occurred at* 6:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marion K. Leighton MD 265	Gooding, Idaho	9-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-8-1967	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
SEPT 8, 1967	Barbara Meyer	Eddie G. Leach	E-511

FIRM NAME: Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUN 12 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Klingler -

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4047
Local Reg. No. 2997
Reg. Dist. No. 420

BIRTH NO.

OCT 3 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF [illegible] (in this place): 880
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hosp. 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Martha Lellaveve
b. (Middle):
c. (Last): Mc Leod

4. DATE OF DEATH (Month) (Day) (Year): Sept. 21, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 27, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & Laundry
10b. KIND OF BUSINESS OR INDUSTRY: Worker
11. BIRTHPLACE (State or foreign country): Gardener, Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ellwood Coles — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Lany Alice Bogart — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 518-30-8048
17. INFORMANT'S OWN SIGNATURE: X Lloyd R. McLeod — ADDRESS: Gooding, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 1. Arteriosclerotic Heart Disease with failure.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Anemia, etiology undetermined.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH: 4-5 days.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 20, 1967, *to* Sept 21, 1967, *that I last saw the deceased alive on* Sept 21, 1967, *and that death occurred at* 7:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marion V. Klingler M.D.
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: 9-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-26-67
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: Sept. 28-67
REGISTRAR'S SIGNATURE: Roberta S. Meyer
25. EMBALMER: Eddie G. Leach
LICENSE NO.: E-511

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 17 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Klingler -

Certificate of Death

State File No. 4048
Local Reg. No. 2996
Reg. Dist. No. 420

RECEIVED
OCT 3 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (If outside place): 800
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hosp 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 817 Nevada St.

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Lawrence
c. (Last): Bolton

4. DATE OF DEATH (Month) (Day) (Year): Sept. 21, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 9th 1915
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinery, Blacksmith-Repairman
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Richfield, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oscar Ernest Bolton — BIRTHPLACE: Georgia
14. MOTHER'S MAIDEN NAME: Grace E. Forkner — BIRTHPLACE: Sweetwater, Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 9-14-40 to 12-9-40
16. SOCIAL SECURITY NO.: 519-01-5434
17. INFORMANT'S OWN SIGNATURE: X Anna Bolton — ADDRESS: Gooding, Idaho

490 X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia, R & L. Lower Lobes — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 2, 1967, *to* Sept 21, 1967, *that I last saw the deceased alive on* Sept 21, 1967, *and that death occurred at* 4:25 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marion 285 V Klingler M.D.
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: 9-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-25-67
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: Sept 28, 1967
REGISTRAR'S SIGNATURE: Robert S. Meyer
25. EMBALMER: Eddi G. Leach
LICENSE NO.: E-511

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Thompson Chapel-Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Klingler –

Certificate of Death

RECEIVED
OCT 3 1967
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4049
Local Reg. No. 2998
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 326 Wyoming St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 326 Wyoming St.

3. NAME OF DECEASED (Type or Print)
a. (First): Thomas
b. (Middle): Le Roy
c. (Last): Wright

4. DATE OF DEATH (Month) (Day) (Year): Sept. 22, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 27, 1894
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 04 Farming & Ranching.
10b. KIND OF BUSINESS OR INDUSTRY: Aggriculture
11. BIRTHPLACE (State or foreign country): Golden City, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Wright
BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Synderillia Spatts
BIRTHPLACE: Marcelline, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 519-34-4420
17. INFORMANT'S OWN SIGNATURE: [signature]
ADDRESS: Gooding, Idaho

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 Min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Saw Only after death, at 4:30 A.M on Sept 22, 1967 *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at* 2:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marion V. Klingler M.D. 285
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: 9-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-25-1967
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: Sept 28, 1968
REGISTRAR'S SIGNATURE: Robert S. Meyer
25. EMBALMER: Eddi G. Leach
LICENSE NO.: E-511

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Thompson Chapel-Gooding, Id.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 4 1967

DEC 21 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Scheer

Certificate of Death

STATE OF IDAHO

State File No. 4050
Local Reg. No. 2991
Reg. Dist. No. 420

BIRTH NO.

RECEIVED OCT 3 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY in this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 533 Washington St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Curtis	Lavell	Bell	Sept. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	Dec. 28, 1913	53				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Navy Warrant Officer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mountain Park, Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William P. Bell — BIRTHPLACE: Oklahoma
14. MOTHER'S MAIDEN NAME: Nettie I. Ferguson — BIRTHPLACE: Jacksboro, Tex.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War 2
16. SOCIAL SECURITY NO.: 569-36-0716
17. INFORMANT'S OWN SIGNATURE: Ottie Bell — ADDRESS: Gooding, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-23, 1967, *to* 9-23, 1967, *that I last saw the deceased alive on* DOA, 19___, *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Maurice E. Steel MD
23b. ADDRESS: Mendell Ida
23c. DATE SIGNED: 9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-28-67
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding Idaho

DATE REC'D BY LOCAL REG.: Sept 28, 1967
REGISTRAR'S SIGNATURE: Vaden D. Sawyer
25. EMBALMER: Eddie G. Leach
LICENSE NO.: E-511

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT. 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 6 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 12 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4051
Local Reg. No. 3000
Reg. Dist. No. 420

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: GOODING 240 131
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WENDELL
c. LENGTH OF STAY (In this place): 39 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HOME 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 240
b. COUNTY: GOODING
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WENDELL
d. STREET ADDRESS (If rural, give location): 405 W. AV. A

3. NAME OF DECEASED (Type or Print)
a. (First): PARIS
b. (Middle): V.
c. (Last): McAFEE

4. DATE OF DEATH (Month) (Day) (Year): SEPT. 26, 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: OCT. 2, 1896
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 06 LABOR
10b. KIND OF BUSINESS OR INDUSTRY: CARPENTER
11. BIRTHPLACE (State or foreign country): MAYNARDSVILLE TENN.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JOHN H McAFEE — BIRTHPLACE: KENTUCKY
14. MOTHER'S MAIDEN NAME: LOU HARVEY — BIRTHPLACE: TENN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 548-12-5088
17. INFORMANT'S OWN SIGNATURE: Julia E. McAfee — ADDRESS: P.O. Box 124 Wendell Idaho

260X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Hemorrhage	minutes
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Cerebral Atherosclerosis	7 yrs
DUE TO (c)	Diabetes Mellitus	10 yrs
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Obesity and Hypertension	20 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-5, 1961, *to* death, 19__, *that I last saw the deceased alive on* 9-20, 1967, *and that death occurred at* 4 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold G. Holsinger, M.D. 240
23b. ADDRESS: Wendell, Ida
23c. DATE SIGNED: 10/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 8/29/1967
24c. NAME OF CEMETERY OR CREMATORY: WENDELL
24d. LOCATION (City, town, or county) (State): GOODING CO. IDAHO.

DATE REC'D BY LOCAL REG.: Oct 6, 1967
REGISTRAR'S SIGNATURE: Kaleen [illegible] Mayer
25. EMBALMER: J. Forrest Weaver — LICENSE NO. E 353
FIRM NAME: Weaver Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 31 1973

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 16 1983

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 17 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4052
Local Reg. No. 49
Reg. Dist. No. 240

BIRTH NO.

SEP 13 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Parkhill Manor 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 180 b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HELEN	ERSKINE	SCHWARZ	Sept. 1 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 3	Aug. 4, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07	Home	Onawa, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fred Erskine	unknown	Emma Jordan	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	532-10-7283-B	Earl W Schwarz	Orofino, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	C.V.A	1 HR
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	GENERALIZED ARTERIOSCLEROSIS 10 YRS	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* MAY, 1963, *to* AUG 31, 1967, *that I last saw the deceased alive on* AUG 31, 1967, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Calvin A Rebb MD	Orofino Idaho	9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 5, 1967	Riverside	Orofino Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 9 1967	Irma Cone	Fyle C. Gilbertson	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency / United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4053
Local Reg. No. 58
Reg. Dist. No. 240

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 6 days 306
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 212 Pine

3. NAME OF DECEASED (Type or Print)
a. (First): ALTA
b. (Middle): ELLEN
c. (Last): McConnell

4. DATE OF DEATH (Month) (Day) (Year): Sept 1, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: June 15, 1896
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Grangeville, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hugh Brady — BIRTHPLACE: Clinton County New York
14. MOTHER'S MAIDEN NAME: Lizzie May Bentley — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Bernice McConnell — ADDRESS: Grangeville, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

584X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Embolism, rgt leg — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Post-operative for — 4 days
DUE TO (c) Cholecystectomy + Benign Polyp of stomach

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: 28 Aug 67
19b. MAJOR FINDINGS OF OPERATION: Cholelithiasis; Large polyp of Stomach (7 cm diam)
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* about, 1947, *to* 1 Sept, 1967, *that I last saw the deceased alive on* 1 Sept, 1967, *and that death occurred at* 5:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald Saltman M.D. 487
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 13 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept 15, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 25 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4054
Local Reg. No. 37
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 210
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 10 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Hill Nursing Home 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 315 North A

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	EDITH	BERTHA	FLINT	September 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	July 28, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Quitman County Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Asa Samuel Wright		Violattie Wood	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 42 3138 B	Mrs. Beulah Briggs	Grangeville, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 5 mins.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Previous Cerebral Vascular accident 3 years prior to death

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* October, 1960, *to* Sept 3, 1967, *that I last saw the deceased alive on* Sept 2, 1967 *and that death occurred at* 5p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm Morrison 313 M.D.	Grangeville, Id.	9/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/6/1967	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 20 1967	Irma Cone	Robert R Hansen Hansen	E 433

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4055
Local Reg. No. 51
Reg. Dist. No. 240

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville, Rural
c. LENGTH OF STAY (in this place): Mrs 400
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Quartz Mt Fire South Fork Area 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 706 N Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): ALFRED
b. (Middle):
c. (Last): SAFFORD

4. DATE OF DEATH (Month) (Day) (Year): Sept 6, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan 26, 1909
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fire Controll Officer 08
10b. KIND OF BUSINESS OR INDUSTRY: Forest Service
11. BIRTHPLACE (State or foreign country): Sandpoint, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Sarah Workman — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 05 2144
17. INFORMANT'S OWN SIGNATURE: X Mrs Roberta Safford — ADDRESS: Grangeville, Idaho

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coron. thromb. c̄ Ac. MI

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerosis
DUE TO (c) + Old Coron. thromb.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* + MI areas, old

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* I did not attend pt. in past, *19___, to ___, 19___, that I last saw the deceased alive on ___, 19___ and that death occurred at* 1:10 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton H. Wiltse, M.D. 621
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 13 Sept. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept. 15, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Harse — LICENSE NO. E433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: [illegible]

DUTIES:

SEP 19 1967

SEP 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4056
Local Reg. No. 53
Reg. Dist. No. 240

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 25 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 724 N D Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 724 North D. Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALLEN	J	KENNEDY	September 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct 31, 1891	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming Carpentery	Farming & Building	Bitterroot Valley, Mont	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Angus D Kennedy	Scotland	Ida May Dunham	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 22 5536	Angus Kennedy	Grangeville, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* about 1950, *to* 6 Sept 1967, *that I last saw the deceased alive on* 6 March 1967, *and that death occurred at* 9:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Altman MD	Grangeville, Idaho	13 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/ /67	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 15, 1967	Lena Comer	Robert R Hansen	E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

MAY 15 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4057
Local Reg. No. 14
Reg. Dist. No. 242

Certificate of Death

RECEIVED
OCT 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (In this place): 1 day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Theresa
b. (Middle):
c. (Last): Goeckner

4. DATE OF DEATH (Month) (Day) (Year): Sept 7 67

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Nov 17 1880
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Seneca, Kansas
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Henry Sprute — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Elizabeth Yunising — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Agatha M Goeckner — ADDRESS: Cottonwood

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1966, *to* 7 Sept, 1967, *that I last saw the deceased alive on* 7 Sept, 1967, *and that death occurred at* 9135A *m., from the causes and on the date stated above.*

23a. SIGNATURE: E D Peffly MD 679 (Degree or title)
23b. ADDRESS: Cottonwood Idaho
23c. DATE SIGNED: 8 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 9 67
24c. NAME OF CEMETERY OR CREMATORY: Catholic
24d. LOCATION (City, town, or county) (State): Cottonwood, Idaho

DATE REC'D BY LOCAL REG.: Sept. 11, 1967
REGISTRAR'S SIGNATURE: Wesley F. Orr M.D. by M
25. EMBALMER: Clifton Uhlorn
LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 25 1967

State File No. 4058
Local Reg. No. 55
Reg. Dist. No. 240

BIRTH NO.

Inform, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Idaho (250)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville, General Hospital (314)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 217 S. Park Street

3. NAME OF DECEASED (Type or Print)
a. (First): CARL
b. (Middle): OLAF
c. (Last): HAGER

4. DATE OF DEATH (Month) (Day) (Year): Sept 8, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 16, 1903

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher 13

10b. KIND OF BUSINESS OR INDUSTRY: Teaching

11. BIRTHPLACE (State or foreign country): Wallace, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Olaf Hager
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Hilma Kellstrom
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 14 6361

17. INFORMANT'S OWN SIGNATURE: Roger Hager sr
ADDRESS: Grangeville, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1778 Metastatic Cancer of Rectal — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Per Ia above

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1960 *to* Sept 8, 1967, *that I last saw the deceased alive on* Sept 8, 1967, *and that death occurred at* 2:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: John Morrison MD (373) (Degree or title)
23b. ADDRESS: Grangeville, Id.
23c. DATE SIGNED: Sept 15, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/11/67
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept 20, 1967
REGISTRAR'S SIGNATURE: Lena Cone

25. EMBALMER: Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4059
Local Reg. No. 52
Reg. Dist. No. 240

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 9 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Hill Nursing Home 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 020
b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
d. STREET ADDRESS (If rural, give location): Council, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) JEFFERSON c. (Last) BROWN

4. DATE OF DEATH (Month) (Day) (Year): Sept 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct 26, 1885	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Orchard	Santa Fee, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Brown	Virginia	Louise Hopkins	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		542-22 8682 A	Robert Hansen	Grangeville, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

260X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Generalized Arteriosclerosis with Strokes — 7 yrs
DUE TO (c): Diabetes Mellitus — yrs.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Diabetic Acidosis. Possible CANCER of Skin — 2 Days / 8 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January, 1967, *to* Sept 11, 1967, *that I last saw the deceased alive on* Sept 11, 1967, *and that death occurred at* 6:25 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William H. Greenwood	M.D.		9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 13, 1967	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 15 1967	Irma Cone	Robert R Hansen Robert Hansen	E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

JUL 15 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 14 2000

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES; Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4060
Local Reg. No. 56
Reg. Dist. No. 240

BIRTH NO. 331

RECEIVED SEP 25 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250 218
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 18 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Hill Nursing Home 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 280 Idaho
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 816 North State

3. NAME OF DECEASED (Type or Print)
a. (First): Francis
b. (Middle): H.
c. (Last): Ackerman

4. DATE OF DEATH (Month) (Day) (Year): September 16, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: February 13, 1924
9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 17 Heavy Eq. Operator
10b. KIND OF BUSINESS OR INDUSTRY: Logging
11. BIRTHPLACE (State or foreign country): Yakima, Washington
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: A.D. Ackerman — BIRTHPLACE: Forest City, N.D.
14. MOTHER'S MAIDEN NAME: Eleanora Kramer — BIRTHPLACE: Watkins, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1949-1950 6
16. SOCIAL SECURITY NO.: 518 20 6694
17. INFORMANT'S OWN SIGNATURE: Bertha Ackerman — ADDRESS: Grangeville, Idaho

18. CAUSE OF DEATH 9108
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): BRAIN Damage with Coma — March 1966 — INTERVAL BETWEEN ONSET AND DEATH: 18 mos

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Head INJURY Accident — Logging — 18 mos
Possible Pneumonia.
~~DUE TO~~ (c): Kidney Damage with repeated infections. — 16 mos

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~: Log fell on him — March 30, 1966
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Woods 09 Logging 13
21c. (CITY, TOWN, OR TOWNSHIP) 020 **(COUNTY)** **(STATE)**: New Meadows, Adams IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): March 30 1966 ? m.
21e. INJURY OCCURRED WHILE AT WORK ☑ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Logging Boom Fell on Him

22. *I hereby certify that I attended the deceased from* 12 Dec, 1966, *to* Sept 11, 1967, *that I last saw the deceased alive on* Sept 11, 1967, *and that death occurred at* 6:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William H Greenwood, M.D. 189
23b. ADDRESS: Grangeville Idaho
23c. DATE SIGNED: 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/19/67
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Sept. 21, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

OCT 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 7 - 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4061
Local Reg. No. 37
Reg. Dist. No. 240

RECEIVED OCT 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 206 West Main

3. NAME OF DECEASED (Type or Print): a. (First) ROBERT A. PUGH; b. (Middle) Also Known As; c. (Last) Archie Robert Pugh

4. DATE OF DEATH (Month) (Day) (Year): September 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed 2	Nov 21, 1881	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Foreman 26	Grain Elevator	Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Granville Pugh	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 12 4870	Hazel Pugh nr	Grangeville, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular tachycardia & asystole — INTERVAL BETWEEN ONSET AND DEATH: few min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart dis — several years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. moderate urinary retention due to prostatic hypertrophy

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* about 1956 *to* 19 Sept, 1967, *that I last saw the deceased alive on* 19 Sept, 1967, *and that death occurred at* 12:20 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Deltman 487	M.D.	Grangeville, Ida.	26 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/21/1967	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 3, 1967	Irma Cone	Robert R Hansen Robert R Hansen	E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

AUG 7 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 26 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4062
Local Reg. No. 58
Reg. Dist. No. 240

Certificate of Death

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia Rural
c. LENGTH OF STAY (in this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewis & Clark Highway 34 Miles East 550

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Tacoma
d. STREET ADDRESS (If rural, give location): 5509 McCord Drive

3. NAME OF DECEASED (Type or Print)
a. (First): DORES
b. (Middle): E.
c. (Last): DARLING

4. DATE OF DEATH (Month) (Day) (Year): September 19, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: May 8, 1904
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Cival Service
10b. KIND OF BUSINESS OR INDUSTRY: McCord Air Force Base
11. BIRTHPLACE (State or foreign country): Steele North Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hiram S Darling — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Jennie Williams — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 539-14-8775
17. INFORMANT'S OWN SIGNATURE: Donald W. Kitchen — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushing blow to chest

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): incompatible c̄ life.
DUE TO (c): Uncontrolled Diabetes.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Lewis + Clark Highway 13
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 250 Idaho, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 19, 67, 12:15 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Lethal Slam to chest, Dashboard

22. *I hereby certify that I attended the deceased from* never, 19__, *to* before, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 12:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton H. Wiltse, M.D. 621
23b. ADDRESS: Grangeville Idaho
23c. DATE SIGNED: 27 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: Sept. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Tacoma Mausoleum
24d. LOCATION (City, town, or county) (State): Tacoma, Wash.

DATE REC'D BY LOCAL REG.: Oct. 12, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Piper Funeral Home So. Tacoma, Wash.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 2 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 7 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

JUL 1 1969

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

NOV 28 1969

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4063
Local Reg. No. 62
Reg. Dist. No. 240

Certificate of Death

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 250 208
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
c. LENGTH OF STAY (in this place) 8½ Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Hill Manor 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 13 Idaho 250
b. COUNTY Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kamiah
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Lucy b. (Middle) c. (Last) Wapsheli

4. DATE OF DEATH (Month) (Day) (Year) September 29, 1967

5. SEX Female
6. COLOR OR RACE Nez Perce Indian 3
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2 Widowed
8. DATE OF BIRTH Dec. 20 1891
9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 01 Wife
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Whitebird, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Oatman BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Mary Looking Glass BIRTHPLACE Whitebird Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs. Loda Sublett ADDRESS Kooskia Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infirmities of age — INTERVAL BETWEEN ONSET AND DEATH 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1967, *to* Sept 29, 1967, *that I last saw the deceased alive on* Sept 29, 1967 *and that death occurred at* 2:55 p m., *from the causes and on the date stated above.*

23a. SIGNATURE 373 (Degree or title) Wm Morrison, M.D.
23b. ADDRESS Grangeville, Idaho
23c. DATE SIGNED 10/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 3 1967
24c. NAME OF CEMETERY OR CREMATORY Kamiah Tribal Cem.
24d. LOCATION (City, town, or county) Kamiah (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 19, 1967
REGISTRAR'S SIGNATURE Irma Cone
25. EMBALMER Robert A Hansen
LICENSE NO. E433
FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4064
Local Reg. No. 9
Reg. Dist. No. 6-40

BIRTH NO.

RECEIVED SEP 22 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jefferson 260 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby Rural 7th Ward
LENGTH OF STAY (in this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 201 East 1st North 100

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 760
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 201 East 1st North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
KATHARINA	JOHANNA BERNADINA	BATES	Sept. 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	June 22, 1923	44				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 01	Home	Germany	Germany

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Heinrich Odenstein	Germany	Maria Ott	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	None	Ernst W Bates	Rigby, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Arteria-sclerotic Heart Disease	2yrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Chronic Alcoholism	Indefinite
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 10, 1967, *to* Sept 5, 1967, *that I last saw the deceased alive on* 9/2, 1967, *and that death occurred at* 1:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Odenstein Hall M.D.	Rigby, Idaho.	9/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 9, 1967	Pioneer	Rigby Jefferson Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
9/9/67	Mrs A G Odenstein	Bruce A. Eckersell	Rigby, Idaho

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUN 1 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of Bruce A. Eckersell Lic. No. E-404 at Rigby, Idaho. on 9/5/1967

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4065
Local Reg. No. 8
Reg. Dist. No. 640

BIRTH NO.

RECF SEP 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jefferson 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Annis
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rte. #1 Lorenzo 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 330
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Archer
d. STREET ADDRESS (If rural, give location): Rte. #1 Thornton

3. NAME OF DECEASED (Type or Print): a. (First) MARY b. (Middle) SOPHIA c. (Last) YOUNG

4. DATE OF DEATH: (Month) Sept. (Day) 8, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	Apr. 16, 1893	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 01	Home	Independence, Idaho.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Isaac Charles Smith	England	Catherine Hannah Galbraith	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-26-1556A	Verge Young	Rte. #1 Thornton, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Congestive heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atrial fibrillation — 8 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Marked hypertension Senile dementia — 10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* August, 1955, *to* Sept, 1967, *that I last saw the deceased alive on* Sept 1, 1967, *and that death occurred at* 3:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Glenn H. Parry 409	M.D.	Rexburg, Idaho.	9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 11, 1967	Sutton	Archer Madison Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/18/67	Mrs A B Eckersell	Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4066
Local Reg. No. 16
Reg. Dist. No. 640

BIRTH NO.

RECEIVED SEP 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jefferson 268 170
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Menan (rural)
c. LENGTH OF STAY (in this place) 70 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1 1/4 Mi. N.W. 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 760
b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Menan (rural)
d. STREET ADDRESS (If rural, give location) 1 1/4 Mi. N.W.

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) WILLIAM c. (Last) HART, Jr.

4. DATE OF DEATH (Month) (Day) (Year) Sept. 12, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Oct. 2, 1886

9. AGE (In years last birthday) 80 | If UNDER 1 YEAR Months | Days | If UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (State or foreign country) West Weber, Utah.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John William Hart
BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Elizabeth Jane Hogge
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 519-10-7723

17. INFORMANT'S OWN SIGNATURE Nellis H. Garner
ADDRESS Rexburg, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Instantly

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myocardial infarction — 1 year

DUE TO (c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-17, 1965, *to* 9-12, 1967, *that I last saw the deceased alive on* 5-22, 1967, *and that death occurred at* 9:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE Ref G. Maley 317 (Degree or title) M.D.

23b. ADDRESS Rexburg, Idaho.

23c. DATE SIGNED 9-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 15, 1967

24c. NAME OF CEMETERY OR CREMATORY Little Butte

24d. LOCATION (City, town, or county) (State) Annis Jefferson Idaho

DATE REC'D BY LOCAL REG. 9/14/67

REGISTRAR'S SIGNATURE Mrs A B Eckersell

25. EMBALMER Bruce A. Eckersell Bruce A. Eckersell LICENSE NO. E-404

FIRM NAME Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4067
Local Reg. No. 11
Reg. Dist. No. 640

BIRTH NO.

RECEIVED SEP 22 1967

1. PLACE OF DEATH
a. COUNTY Jefferson 260 fee 12
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rigby
c. LENGTH OF STAY (in this place) 12 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 274 North State St. 502

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 260
b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rigby,
d. STREET ADDRESS (If rural, give location) 274 North State St.

3. NAME OF DECEASED (Type or Print) a. (First) VERNAL b. (Middle) BUCKLAND c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) Sept. 16, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 4, 1920
9. AGE (In years last birthday) 47 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Dry Cleaning
10b. KIND OF BUSINESS OR INDUSTRY Business.
11. BIRTHPLACE (State or foreign country) Sunneydell, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Carl L. Buckland. BIRTHPLACE Bountiful, Utah
14. MOTHER'S MAIDEN NAME Bessie Josephine Wheaton. BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 2
16. SOCIAL SECURITY NO. 518-14-2148
17. INFORMANT'S OWN SIGNATURE Lucile Buckland ADDRESS Rigby, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound in head — INTERVAL BETWEEN ONSET AND DEATH: inst.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Rigby 260 Jefferson Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept. 16, 1967 8:10P
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Self inflicted

22. *I hereby certify that I attended the deceased from* [illegible] *to* [illegible] *that I last saw the deceased alive on* [illegible] *and that death occurred at* 8:10P *m., from the causes and on the date stated above.*

23a. SIGNATURE Norman Toolf 583 (Degree or title) Coroner 4
23b. ADDRESS Rigby, Idaho
23c. DATE SIGNED 9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/19/1967
24c. NAME OF CEMETERY OR CREMATORY Little Butte
24d. LOCATION (City, town, or county) (State) Annis, Jefferson, Idaho

DATE REC'D BY LOCAL REG. 9/18/67
REGISTRAR'S SIGNATURE Mrs. B. Eckersell
25. EMBALMER Bruce A. Eckersell Bruce A. Eckersell LICENSE NO. E 404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JUN 12 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4068
Local Reg. No. 1024
Reg. Dist. No. 440

BIRTH NO.

RECEIVED SEP 18 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Jerome 270 317

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome

c. LENGTH OF STAY (in this place): 17 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 699

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 161

b. COUNTY: Cassia

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley 83318

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)

a. (First): James

b. (Middle): William

c. (Last): Elliott

4. DATE OF DEATH (Month) (Day) (Year): Sept. 3, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 9, 1884

9. AGE (In years last birthday): 83

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): California

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: John Charles Elliott - Kentucky

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Susan Elizabeth McCroskey - Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 525-16-9431C

17. INFORMANT'S OWN SIGNATURE: Wayne E. Elliott — ADDRESS: Jerome, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chr. bronchitis + pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis, moderate

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* August 16, 1967, *to* _____, 1967, *that I last saw the deceased alive on* Sept. 2, 1967, *and that death occurred at* 10:05 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Jon D. Wilmoth, M.D. (Degree or title): 270

23b. ADDRESS: 216 E. Main St. Jerome Ida

23c. DATE SIGNED: Sept. 6, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 9/3/67

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cem.

24d. LOCATION (City, town, or county) (State): Burley, Idaho 83318

DATE REC'D BY LOCAL REG.: Sept. 11 1967

REGISTRAR'S SIGNATURE: Louella M. Deberer

25. EMBALMER: Retta S. Payne — LICENSE NO.: E. 358

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 27 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4069
Local Reg. No. 1026
Reg. Dist. No. 440

Certificate of Death

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho. 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
d. STREET ADDRESS (If rural, give location): Rural Route

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Albert
c. (Last): Smith

4. DATE OF DEATH (Month) (Day) (Year): Sept. 3 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 2
8. DATE OF BIRTH: Aug. 14 1898
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 04 Cattle and Horse rancher
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Moencoi, Arizona
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Lot Smith — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Alice Ann Richards — BIRTHPLACE: Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-58-8357-J1
17. INFORMANT'S OWN SIGNATURE: Chapel Mortimers Record — ADDRESS: Ogden, Utah.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hepatic Coma — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cirrhosis, Uremia
DUE TO (c): Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic heart disease

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* Sept 3, 1967, *that I last saw the deceased alive on* Sept 3, 1967, *and that death occurred at* 1145 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Howard C. Luke M.D. 311
23b. ADDRESS: Box 186 Hazelton Ida
23c. DATE SIGNED: 9/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-8-1967
24c. NAME OF CEMETERY OR CREMATORY: Aultorest Mem. Park
24d. LOCATION (City, town, or county) (State): Ogden Utah.

DATE REC'D BY LOCAL REG.: Sept. 12, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: Robert S. Meyer
LICENSE NO.: E-424

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Thompson Chapel--Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 17 1998

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4070
Local Reg. No. 1025
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) County Rd. 3 mi. so.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 120
b. COUNTY Butte
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco (rural)
d. STREET ADDRESS (If rural, give location) Rt. 1 (Butte City)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	THERON	DENNIS	JACOBSEN	Sept. 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Oct. 2, 1945	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Custom Farming	Rexburg, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Herman D. Jacobsen	Driggs, Ida.	Gwen Hatt	Tetonia, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 52 7131	X (Theron Jacobsen)	Rt. 1, Arco, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Skull fracture and multiple injuries

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH
(a) 3234
(b) none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Auto	Hwy 26 E. of Jerome	270 Jerome Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		Pick-up and car collision.

22. *I hereby certify that I attended the deceased from* Sept. 5, 19 67, *to* ———, 19——, *that I last saw the deceased alive on* ———, 19——, *and that death occurred at* 3:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arthur Lee Ashton	Coroner	Jerome	6 Sep 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 8, 1967	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 11 1967	Lenella M. Delaney	W. L. Hove	E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 7 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4071
Local Reg. No. 1027
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 12 hrs 412
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 404 Adams 83301

3. NAME OF DECEASED (Type or Print)
a. (First): DOROTHY
b. (Middle): BEATRICE
c. (Last): RHOADES

4. DATE OF DEATH (Month) (Day) (Year): Sept. 8, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Sept. 25, 1924
9. AGE (In years last birthday): 42 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Archer City, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Marvin Rushing — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Lillie May Boskwick — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - - - - - -
16. SOCIAL SECURITY NO.: 460-36-3125
17. INFORMANT'S OWN SIGNATURE: James F Rhoades — ADDRESS: Twin Falls, Idaho 83301

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma of Rt breast — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Cervix — 5 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): - - - - - -
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): - - - - - - - - - - - - - - - - - 6 -
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): - - - - m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: - - - - - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* 8/18/61, 19__, *to* death, 19__, *that I last saw the deceased alive on* 9/8/67, 19__, *and that death occurred at* 9 45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold D. Holsmyer M.D. 240
23b. ADDRESS: Jerome, Idaho — Wendell, Ida
23c. DATE SIGNED: 9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9-12-67
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.: Sept. 14, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: Dale P. Patterson — LICENSE NO.: E-451

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: TWIN FALLS MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 29 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Rec'd Sept 29, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4072
Local Reg. No. 1032
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 600
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 300
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry 83623
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Jesse; b. (Middle); c. (Last) Duncan

4. DATE OF DEATH: (Month) Sept. (Day) 15, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 3, 1884
9. AGE (In years last birthday): 83 (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY: R. R. Carman
11. BIRTHPLACE (State or foreign country): Gainesville, Mo.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: S. D. Duncan — BIRTHPLACE: Mo.
14. MOTHER'S MAIDEN NAME: Mary C. Bryant — BIRTHPLACE: Mo.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 712-03-9124
17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Hortense M. Gabrielson, 196W. Alameda Rd. Pocatello, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Concussion Hemorrhage into chest & multiple fractures — INTERVAL BETWEEN ONSET AND DEATH: ½ Hr.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) ribs & R leg.
DUE TO (c) Auto accident

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hiway 13
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Jerome 270 Jerome Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9-15-67 4:30p m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto

22. *I hereby certify that I attended the deceased from* Sept 15, 19 67, *to* Sept 15, 1967, *that I last saw the deceased alive on* Sept 15, 19 67, *and that death occurred at* 6:15p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. E. Sloat, M.D. 476
23b. ADDRESS: Jerome, Idaho
23c. DATE SIGNED: 9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 9-19-67
24c. NAME OF CEMETERY OR CREMATORY: Glen Rest
24d. LOCATION (City, town, or county) (State): Elmore Co. Idaho

DATE REC'D BY LOCAL REG.: Sept 29, 1967
REGISTRAR'S SIGNATURE: W. W. Benson
25. EMBALMER: J. Forrest Weaver
LICENSE NO.: E-353

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Weaver Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 1032
Reg. Dist. No. 440

RECEIVED SEP 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: JEROME
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): JEROME 83338
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. BENEDICT

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: ELMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): GLENNS FERRY 83623
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JESSE
b. (Middle):
c. (Last): DUNKIN

4. DATE OF DEATH (Month) (Day) (Year): SEPT. 15, 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED
8. DATE OF BIRTH: APR. 3, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY: R.R. CARMAN
11. BIRTHPLACE (State or foreign country): Gainesville MO.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: S. D. DUNCAN — BIRTHPLACE: MO.
14. MOTHER'S MAIDEN NAME: MARY C. BRYANT — BIRTHPLACE: MO.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 712-03-9121
17. INFORMANT'S OWN SIGNATURE: Hortense M. Gabrielson 1960 — ADDRESS: Alameda Ld. Pocatello Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Brain Concussion Hemorrhage into chest & multiple fractures
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ribs & R leg.
DUE TO (c): auto accident

INTERVAL BETWEEN ONSET AND DEATH: ½ hr.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hiway
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Jerome Jerome Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9/15/67 4:30 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 15, 1967, *to* Sept 15, 1967, *that I last saw the deceased alive on* Sept 15, 1965, *and that death occurred at* 8:25 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. E. Moore MD
23b. ADDRESS: Jerome Idaho
23c. DATE SIGNED: 9/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL
24b. DATE: 9/19/1967
24c. NAME OF CEMETERY OR CREMATORY: GLENNREST
24d. LOCATION (City, town, or county) (State): ELMORE CO. IDAHO.

DATE REC'D BY LOCAL REG.: Sept. 28, 1967
REGISTRAR'S SIGNATURE: Louella M. Dokerer
25. EMBALMER: J. Forrest Weaver — LICENSE NO.: 2353
FIRM NAME: Weaver Martway

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT - 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 19 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4073
Local Reg. No. 1031
Reg. Dist. No. 440

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 270 JEROME 5005
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) JEROME 83338
c. LENGTH OF STAY (in this place) MINUTES
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST. BENEDICT 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 200
b. COUNTY ELMORE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) GLENNS FERRY 83623
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) ELEANOR b. (Middle) M. c. (Last) DUNCAN

4. DATE OF DEATH (Month) (Day) (Year) SEPT. 15. 1967

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3 MARRIED
8. DATE OF BIRTH APR, 12, 1888
9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 01 HOUSEWIFE AND
10b. KIND OF BUSINESS OR INDUSTRY L.P.N.
11. BIRTHPLACE (State or foreign country) WOODRUFF IDAHO
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME HENRY LISH BIRTHPLACE MO.
14. MOTHER'S MAIDEN NAME LEOLLA NORTON BIRTHPLACE S.L.C. UTAH.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) n NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-14-9070
17. INFORMANT'S OWN SIGNATURE Hortense M. Gabrielson 1962 Alameda Rd. Pocatello Idaho ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Basilar skull fracture 8254

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) + Fracture rt leg
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 20 min.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 1 accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 06 H. Way
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 Jerome 270 Jerome, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9/15/67 4 30 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Auto

22. *I hereby certify that I attended the deceased from* 9/15, 1967, *to* 9/15, 1967, *that I last saw the deceased alive on* 9/15 1967, *and that death occurred at* 5 25 P *m., from the causes and on the date stated above.*

23a. SIGNATURE J. E. Moore 476 (Degree or title) 1 MD.
23b. ADDRESS Jerome Ida
23c. DATE SIGNED 9/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL
24b. DATE 9/19/1967
24c. NAME OF CEMETERY OR CREMATORY GLENREST
24d. LOCATION (City, town, or county) (State) ELMORE CO. IDAHO.

DATE REC'D BY LOCAL REG. Sept. 28, 1967
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER J. Forrest Weaver
LICENSE NO. E-353
FIRM NAME: Weaver Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT - 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 26 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4074
Local Reg. No. 1028
Reg. Dist. No. 440

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton
LENGTH OF STAY (in this place): 15 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route #1 Hazelton, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Hazelton
d. STREET ADDRESS (If rural, give location): Route #1 83335

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	LEO	HOFFMAN	September 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 27, 1903	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Janitorial	Lynch, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Hoffman	Germany	Louise Smith	UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	508-14-8469	x Mrs John Hoffman	Hazelton,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Thrombosis	5 MO
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerosis	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug, 1967 *to* Sept 15 1967, *that I last saw the deceased alive on* Sept 12, 1967, *and that death occurred at* 3 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Howard C. Lisle MD	Box 1867 Ketchum Ida	9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9.20.67	TwinFalls, Cem.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 21, 1967	Louella M. Scherer		E-343

FIRM NAME: WHITE MORTUARY 73

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State "unknown" only after a careful investigation. Use BLACK ink or BLACK typewriter ribbon in filling out certificate. (ID. J.E. IDAHO 3-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4075
Local Reg. No. 1033
Reg. Dist. No. 440

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 270 JEROME 402
b. CITY OR TOWN JEROME 83338
LENGTH OF STAY (In this place) 2. HOURS
d. FULL NAME OF HOSPITAL OR INSTITUTION ST. BENEDICT 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 240 b. COUNTY GOODING
c. CITY OR TOWN WENDELL 83355
d. STREET ADDRESS (If rural, give location) 647 E. AV. A.

3. NAME OF DECEASED (Type or Print): a. (First) ARMIN b. (Middle) L c. (Last) WEISMAN
4. DATE OF DEATH (Month) (Day) (Year): SEPT. 18. 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: JAN. 25, 1891
9. AGE (In years last birthday): 76 (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED 29
10b. KIND OF BUSINESS OR INDUSTRY: FARMER
11. BIRTHPLACE (State or foreign country): DUBOIS CO. INDIANA
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN WEISMAN — BIRTHPLACE: INDINIA
14. MOTHER'S MAIDEN NAME: LOUISA HANNEBUTT — BIRTHPLACE: INDINIA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-36-7109
17. INFORMANT'S OWN SIGNATURE: Gerald Weisman ADDRESS: Rt 3 Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 10 yrs
DUE TO (c) Arteriosclerosis — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Osteoarthritis — 15 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-5-43, 19___, *to* Death, 19___, *that I last saw the deceased alive on* 9-18-67, 19___, *and that death occurred at* 2 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold G. Holsinger MD 240
23b. ADDRESS: Wendell, Ida
23c. DATE SIGNED: Oct. 3, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9/21/1967
24c. NAME OF CEMETERY OR CREMATORY: WENDELL
24d. LOCATION (City, town, or county) (State): GOODING CO. IDAHO.

DATE REC'D BY LOCAL REG.: Oct. 4, 1967
REGISTRAR'S SIGNATURE: Lucille M. Dobson
25. EMBALMER: J. Forest Weaver — LICENSE NO.: E353
FIRM NAME: Weaver Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4076
Local Reg. No. 1029
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

270

1. PLACE OF DEATH
a. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 304 East Ave. "B" 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 270
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 304 East Ave. "B"

3. NAME OF DECEASED (Type or Print)
a. (First): ALVIN
b. (Middle): EDNEY
c. (Last): GRANT

4. DATE OF DEATH (Month) (Day) (Year): Sept. 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 29, 1913
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Businessman 21
10b. KIND OF BUSINESS OR INDUSTRY: Dry Cleaning
11. BIRTHPLACE (State or foreign country): Hendersonville, No. Carolina
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: V. E. Grant — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Blanche Edney — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 494 05 1228
17. INFORMANT'S OWN SIGNATURE: Mrs. Mosley Grant — ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic Emphysema — yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1957, *to* 18 Sep, 1967, *that I last saw the deceased alive on* 17 Sep, 1967, *and that death occurred at* 11:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [illegible] 385
23b. ADDRESS: Jerome
23c. DATE SIGNED: 22 Sep 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: Sept. 25, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4077
Local Reg. No. 1030
Reg. Dist. No. 440

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 83338 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell 83355
d. STREET ADDRESS (If rural, give location): P.O. Box 551

3. NAME OF DECEASED (Type or Print)
a. (First): Wilma
b. (Middle): Geraldine
c. (Last): Passmore

4. DATE OF DEATH (Month) (Day) (Year): Sept. 23, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Feb. 5, 1919
9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Keeper-Wendell
10b. KIND OF BUSINESS OR INDUSTRY: Rest Home
11. BIRTHPLACE (State or foreign country): Buhl, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Morton Henry Passmore — BIRTHPLACE: Brookland, Ind.
14. MOTHER'S MAIDEN NAME: Flossie B. Ravenscroft — BIRTHPLACE: Eureka, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 569-34-1331
17. INFORMANT'S OWN SIGNATURE: X Flossie Passmore — ADDRESS: Wendell, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5 7 8 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute gastro-entero-dilatation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) & hemorrhage
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. multiple small emboli

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11-, 1956, *to* 9-23-, 1967, *that I last saw the deceased alive on* 9-23-, 1967, *and that death occurred at* 3:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Maurice E. Scheel MD 4576
23b. ADDRESS: Wendell, Idaho
23c. DATE SIGNED: 9-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-26-1967
24c. NAME OF CEMETERY OR CREMATORY: Wendell Cemetery
24d. LOCATION (City, town, or county) (State): Wendell Idaho

DATE REC'D BY LOCAL REG.: Sept. 27, 1967
REGISTRAR'S SIGNATURE: Louella M. Dekerer
25. EMBALMER: Robert S. Meyer — LICENSE NO.: E-424

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Thompson Chapel, Gooding, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 OCT 4 1967 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 4 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4078
Local Reg. No. 1034
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): 100
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 270
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 513 6th. Ave. West

3. NAME OF DECEASED (Type or Print)
a. (First): EDITH
b. (Middle): EMMA 099
c. (Last): McCREARY

4. DATE OF DEATH (Month) (Day) (Year): Sept. 25, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 27, 1887
9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Oakley, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: no record
BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: no record
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: X Mrs Frank Mc Creary
ADDRESS: BOX 455 Shoshone, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Superior mesenteric artery / Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Mitral Stenosis Heart — 4 yrs
DUE TO (c) atrial fibrillation + Cardiac decompensation

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/16, 1963 *to* Sept 25, 1967, *that I last saw the deceased alive on* Sept 25, 1967, *and that death occurred at* 7:40P m., *from the causes and on the date stated above.*

23a. SIGNATURE: 476 (Degree or title): MD
23b. ADDRESS: Twin Falls Ida 83338
23c. DATE SIGNED: 9/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 3, 1967
REGISTRAR'S SIGNATURE: Louella M. Doherer
25. EMBALMER: N. L. Hove
LICENSE NO.: E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-69021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4079
Local Reg. No. 1033
Reg. Dist. No. 440

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (in this place): 100
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 270
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 409 East Ave. "C"

3. NAME OF DECEASED (Type or Print)
a. (First): MAUDE
b. (Middle): ZETTA
c. (Last): HAMLETT

4. DATE OF DEATH (Month) (Day) (Year): Sept. 26, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 13, 1890
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Knox City, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Lewis — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Mary J. Meadows — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 03 1269B
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 4/8/67
19b. MAJOR FINDINGS OF OPERATION: Obstructive carcinoma of splenic colon
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 8/18/67, 19__, *to* 9/25/67, 19__, *that I last saw the deceased alive on* 9/25/67, 19__, *and that death occurred at* 1:10 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Carlyle Smail 477 MD
23b. ADDRESS: Jerome, Idaho 83338
23c. DATE SIGNED: 9/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: Sept. 27, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4080
Local Reg. No. 179
Reg. Dist. No. 120

RECEIVED
SEP 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp 10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hayden Lake
d. STREET ADDRESS (If rural, give location) Rt# 1

3. NAME OF DECEASED (Type or Print) a. (First) Jesse b. (Middle) Paul c. (Last) Sage

4. DATE OF DEATH (Month) (Day) (Year) Sept. 2, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 3-29-1883

9. AGE (In years last birthday) 84
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Anamosia, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Anthony Sage
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Minerva Streeter
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-18-7398A

17. INFORMANT'S OWN SIGNATURE Mrs. Eva M. Sage
ADDRESS Hayden Lk, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident — 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — Years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

33/X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-2, 1967, *to* 9-2, 1967, *that I last saw the deceased alive on* 9-2, 1967, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 026 M.D.

23b. ADDRESS Coeur d'Alene Idaho

23c. DATE SIGNED 9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-6-1967

24c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Aug 7 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4081
Local Reg. No. 492
Reg. Dist. No. 120

BIRTH NO.

SEP 11 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 18 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 624 Foster Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Gotthilf b. (Middle) 101 c. (Last) Doering, Jr.

4. DATE OF DEATH (Month) (Day) (Year) Sept. 2, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH 12-10-1888

9. AGE (In years last birthday) 78 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant 22

10b. KIND OF BUSINESS OR INDUSTRY retired

11. BIRTHPLACE (State or foreign country) Tripp, South Dakota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gotthilf Doering | BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Karolina Boethcher | BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 516-09-7192

17. INFORMANT'S OWN SIGNATURE Mrs. Martha Doering | ADDRESS Coeur d' A. Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis, Cerebral

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 51, *to* _____, 19 67, *that I last saw the deceased alive on* Sept 2, 1967, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Wm Templeton, MD

23b. ADDRESS 302 N 5th

23c. DATE SIGNED 5 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9-6-1967

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Aug 7, 1967

REGISTRAR'S SIGNATURE Lorraine K. Breuch

25. EMBALMER Fredd H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4082
Local Reg. No. 777
Reg. Dist. No. 120

RECEIVED Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 11 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Kootenai 280 106

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rathdrum

c. LENGTH OF STAY (in this place): 6 yrs.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 mls. N.W. of Rathdrum 176

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 280

b. COUNTY: Kootenai

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rathdrum

d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print)

a. (First): Anton

b. (Middle): Warner

c. (Last): Erickson

4. DATE OF DEATH: (Month) Sept. (Day) 2, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Marridd

8. DATE OF BIRTH: 5-18-1920

9. AGE (In years last birthday): 47

IF UNDER 1 YEAR — Months / Days

IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Wallace, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Anton L. Erickson

BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Jennie Nord,

BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Mrs. Alice Shove,

ADDRESS: Wantch. Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): probable acute Coronary occlusion

INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Wood, M.D. Coroner

23b. ADDRESS: Coeur d'alene Idaho

23c. DATE SIGNED: 9-6-'67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-5-1967

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Aug 7, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred H. Noland

LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-9097

BIRTH NO.

Certificate of Death

RECEIVED STATE OF IDAHO

SEP 29 1967 281

Bureau of Vital Statistics

State File No. 4083
Local Reg. No. 185
Reg. Dist. No. 120

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (If not in this place): 880
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 280
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Athol
d. STREET ADDRESS (If rural, give location): P.O. Box 26

3. NAME OF DECEASED (Type or Print)
a. (First): YVONNE
b. (Middle): PATRICE
c. (Last): VORCE

4. DATE OF DEATH (Month) (Day) (Year): Sept. 3 1967

5. SEX: Female
6. COLOR OR RACE: Wh
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: Sept. 3, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.: 3
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Coeur d'Alene, Idaho
12. CITIZEN OF WHAT COUNTRY?: United States
13. FATHER'S NAME: CHARLES WILLIAM VORCE — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: PATRICIA LEE KONZE — BIRTHPLACE: Minnesota
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: MRS. PATRICIA L. VORCE — ADDRESS: Athol, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

776X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Marked prematurity

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): None
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): None m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 3, 1967, *to* Sept. 3, 1967, *that I last saw the deceased alive on* Sept. 3, 1967, *and that death occurred at* 11 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. H. [signature] MD 0658
23b. ADDRESS: Hayden Lake, Idaho
23c. DATE SIGNED: 9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: Sept. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kootenai Memorial Hospital
24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: Sept 25, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. ~~EMBALMER~~ Pathologist: Allen D. Stier M.D.
LICENSE NO.:

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician The hospital was misinformed in this regard.

Certificate of Death

STATE OF IDAHO

State File No. 4084
Local Reg. No. 183
Reg. Dist. No. 12

BIRTH NO.

SEP 22 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry	G.	Tipke	Sept. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	10-22-1907	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	Cement Plant	Odessa, Washington	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John T. Tipke	Minn.	Bertha Neubaur	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	539-07-3292	Mrs. Ethel Tipke	Post Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial Infarction	2 hour
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* 9/7/67, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

Dead on arrival at hospital--Not seen by me prior to this time

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Coeur d' Alene	9/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-11-1967	Restlawn Memorial Pk.	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 19, 1967	Lorraine K. Breuch	Fred H. Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 22 1967 Bureau of Vital

Certificate of Death

STATE OF IDAHO

State File No. 4085
Local Reg. No. 181
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 2-yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor Nursing H 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle) Frances
c. (Last) Stang

4. DATE OF DEATH (Month) (Day) (Year) Sept. 7, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Jan. 19, 1878
9. AGE (In years last birthday) 89 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Kenton, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Francis Gastinger — BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Mary Custer — BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-03-9275
17. INFORMANT'S OWN SIGNATURE Springfield Ore — ADDRESS Arthur Conrad Stang

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1964, to _____, 1967, that I last saw the deceased alive on Aug 30, 1967, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE D M Gunnwald M.D. (Degree or title) 192
23b. ADDRESS 302 N 5th Ave
23c. DATE SIGNED 14 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-11-67
24c. NAME OF CEMETERY OR CREMATORY Pinegrove Cemetery
24d. LOCATION (City, town, or county) Rathdrum (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 18, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Duff
LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel, Coeur d'Alene

SEP 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 22 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4086
Local Reg. No. 180
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post FAlls
c. LENGTH OF STAY (in this place): 60
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pleasant View 336

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 280
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): Pleasant View

3. NAME OF DECEASED (Type or Print): a. (First) Lawrence b. (Middle) M. c. (Last) Richmond

4. DATE OF DEATH (Month) (Day) (Year): Sept. 8, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 13, 1889

9. AGE (In years last birthday): 77 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 84

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Missouri

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: George Richmond — BIRTHPLACE: ------

14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE: ----------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-22-1858

17. INFORMANT'S OWN SIGNATURE: X George M. Richmond — ADDRESS: Lake, Hayden Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 12 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov, 1952, *to* 9-8, 1967, *that I last saw the deceased alive on* 9-1, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: X Robt Bingham 197 MD (Degree or title)

23b. ADDRESS: 512 W 8th Spokane Wash.

23c. DATE SIGNED: 9-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9-11-67

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Park

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Sept 14 1967

REGISTRAR'S SIGNATURE: Lorraine R. Brush

25. EMBALMER: M. K. Tiplinger Jr. — LICENSE NO.: E-397

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4087
Local Reg. No. 184
Reg. Dist. No. 120

RECEIVED SEP 22 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinewood Manor Nursing Home 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 1143 11th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Helen
b. (Middle):
c. (Last): Wagar

4. DATE OF DEATH (Month) (Day) (Year): Sept. 13, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct. 8, 1881
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): North Dakota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: B. A. Umphrey — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Marie Hunt — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-16-2555T
17. INFORMANT'S OWN SIGNATURE: Mrs. Doris Stevens (BD) — ADDRESS: Ida. Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-17, 1965, *to* 9-13, 1967, *that I last saw the deceased alive on* 9-12, 1967, *and that death occurred at* 1:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Barclay M.D. 026
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-15-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Sept. 18, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Duff
LICENSE NO.: E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Wilson

Certificate of Death

STATE OF IDAHO

State File No. 4088
Local Reg. No. 182
Reg. Dist. No. 120

BIRTH NO.

RECEIVED SEP 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28/
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 200
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28/
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print) a. (First) Daisy b. (Middle) Lillian c. (Last) Taylor
4. DATE OF DEATH (Month) (Day) (Year) September 14, 67
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH 1-26-1883
9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 07
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY U.S.A.
13. FATHER'S NAME Linus Thayer BIRTHPLACE Unobtainable
14. MOTHER'S MAIDEN NAME Elizabeth Leaver BIRTHPLACE Unobtainable
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-03-3276
17. INFORMANT'S OWN SIGNATURE Art Olson (AO) ADDRESS Coeur d'Alene, Ida

4200

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure. — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio sclerotic heart disease — 12 years
DUE TO (c) Generalized arterio sclerosis — many years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bilat. pulmonary effusion — 1 year

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1959, *to* Sept 14, 1967, *that I last saw the deceased alive on* Sept 13, 1967, *and that death occurred at* 12:05 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) W. Wray Wilson MD
23b. ADDRESS Coeur d'Alene
23c. DATE SIGNED 9-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9-18-67
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Ida.

DATE REC'D BY LOCAL REG. Sept. 18 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Wolff
LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 9 1967

FEB 29 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4089
Local Reg. No. 187
Reg. Dist. No. 120

BIRTH NO.

RECEIVED OCT 6 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY IN THIS PLACE: 281 280
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Medimont
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Olive
b. (Middle): M.
c. (Last): Burlingame

4. DATE OF DEATH: (Month) Sept. (Day) 21, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 28, 1887

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own HOme

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oscar F. Berg
BIRTHPLACE: ----------

14. MOTHER'S MAIDEN NAME: Ansdella M. Hall
BIRTHPLACE: ----------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 538-26-5484A

17. INFORMANT'S OWN SIGNATURE: X Olive A. Thompson ADDRESS Rt #2, St Maries Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Renal failure

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-1-67 19__, *to* 9-21, 1967, *that I last saw the deceased alive on* 9-21, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Rusch 25 MD
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED: 9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-25-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Sept. 29, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: N. G. Ripslinger, Jr.
LICENSE NO.: E-397

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4090
Local Reg. No. 186
Reg. Dist. No. 120

BIRTH NO.

RECEIVED OCT 6 1967 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 | 30
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place): 1 WK
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 28 | b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 716 B. St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lewis	Henry	Brown	Sept. 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 5	12-23-1884	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Supervisor 26
10b. KIND OF BUSINESS OR INDUSTRY: Forest Service
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sanford Brown — BIRTHPLACE: Unobtainable
14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. I 3
16. SOCIAL SECURITY NO.: 542-32-8723
17. INFORMANT'S OWN SIGNATURE: X Kathryn L. Brown — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Peri-prostatic Thrombo-phlebitis — Unknown
Adeno-carcinoma of prostate — Years
DUE TO (c) Without Stricture with known tract urinary infection — Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 22 Sep 67
19b. MAJOR FINDINGS OF OPERATION: Bulbous urethral stricture
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* 25 Sep, 1967, *that I last saw the deceased alive on* 24 Sep, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert H. Young, M.D. 786 (Degree or title)
23b. ADDRESS: 411 Coeur d'Alene Ave. Coeur d'Alene, Idaho
23c. DATE SIGNED: 29 Sep 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-28-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Vet. Plot-Coeur d'Alene Ida.

DATE REC'D BY LOCAL REG.: Sept. 29, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Huff — LICENSE NO.: E-439
FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 124091
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah
OCT 9 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
c. LENGTH OF STAY (in this place): 19 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rural Kendrick

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
d. STREET ADDRESS (If rural, give location): P.O. Box 103

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	FREDERICK	GUIER	Sept. 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married	Nov. 4, 1895	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer	Farming	Johnson County, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas J. Guier	Missouri	Julia E. Wicker	North Caroline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No		Mrs Jack Guier	Kendrick Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of the lung — INTERVAL BETWEEN ONSET AND DEATH: 1 1/2 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* Called at Death *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D.A. Chesterman MD	Kendrick Idaho	9-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	9/7/1967	Asotin City Cemetery	Asotin, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-8-67	Lynette Knott	Robert Lorabee	802

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: MERCHANT FUNERAL HOME

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 1154092
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO. RF

SEP 19 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 291 2-01 322
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 22 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 290
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Potlatch
d. STREET ADDRESS (If rural, give location): 655 6th Street

3. NAME OF DECEASED (Type or Print)
a. (First): AUSTIN
b. (Middle): ALVIN
c. (Last): MOODY

4. DATE OF DEATH (Month) (Day) (Year): September 4, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: January 4, 1915
9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Potlatch Forests.
11. BIRTHPLACE (State or foreign country): Moscow, Vermont
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Spencer H. Moody — BIRTHPLACE: Moscow, Vermont
14. MOTHER'S MAIDEN NAME: Mary Austin — BIRTHPLACE: Lake Clear, N. Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War II 4201
16. SOCIAL SECURITY NO.: 519-09-4861
17. INFORMANT'S OWN SIGNATURE: Albert H. Moody — ADDRESS: Potlatch, Idah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive failure
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Acute posterior wall
DUE TO (c): myocardial infarction with extension of infarction

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-15, 1965, *to* Sept 4, 1967, *that I last saw the deceased alive on* Sept 4, 1967, *and that death occurred at* 7:45 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Joseph H. Wilson 567 (Degree or title) MD
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-7-1967
24c. NAME OF CEMETERY OR CREMATORY: Potlatch Cemetery
24d. LOCATION (City, town, or county) (State): Potlatch, Idaho

DATE REC'D BY LOCAL REG.: 9-18-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: H E Kimball
LICENSE NO.: E 269

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Kimball Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 21 1967

SEP 27 1967

APR 1 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended October 16, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4093
Local Reg. No. 116
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 290 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Juliaetta
c. LENGTH OF STAY (in this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 290
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Juliaetta
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Herbert; b. (Middle) Charles; c. (Last) Weber

4. DATE OF DEATH: (Month) (Day) (Year) September 5, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 2, 1903

9. AGE (In years last birthday): 64 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 27

10b. KIND OF BUSINESS OR INDUSTRY: Farm Machinery

11. BIRTHPLACE (State or foreign country): Kendrick, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Weber
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Elsie Comstock
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 531-16-5019

17. INFORMANT'S OWN SIGNATURE: Mamie Weber
ADDRESS: Juliaetta, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 20 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Atherosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Obstructive emphysema

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct, 1963, *to* Aug, 1967, *that I last saw the deceased alive on* 15 Aug, 19 67, *and that death occurred at* 12:05A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. B. Britzmann, M.D. 057
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: Sept 9, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 5 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-18-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: K. H. Malcom
LICENSE NO.: # 376

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend an Original Certificate of Birth or Death

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

State of Idaho
County of Nez Perce } ss.

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Herbert Charles Weber (Name on Original Certificate) who Died (Was Born or Died) on 5 Sept 1967 (Date of Event)
in Juliaetta, Latah Co., Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by Bible Record (Bible Record, Insurance Policy, Etc.) prepared on (50 years ago) (Give Date) are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	2 March 1902	2 March 1903
Date Dr. Signed Certificate	9 Aug 1967	9 Sept. 1967
	Age 65	age 64

Subscribed and sworn to before me this 3rd day of Oct., 1967

W. E. Black

Notary Public, residing at W. E. Black, Notary Public
My commission expires Lewiston, NezPerce Co., Ida.
(Seal) My Commission Expires 3-6-68

Signed Mrs. Dennis Lehman
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

3519 - 12th St., Lewiston, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Nez Perce } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 3rd day of Oct., 1967

W. E. Black

Notary Public, residing at W. E. Black, Notary Public
My commission expires Lewiston, NezPerce Co., Ida.
(Seal) My Commission Expires 3-6-68

Signed Mrs. Minnie Weber
(Signature of Any Credible Person)

Juliaetta, Idaho
(Street Address, City, State)

FORM DH 60-155

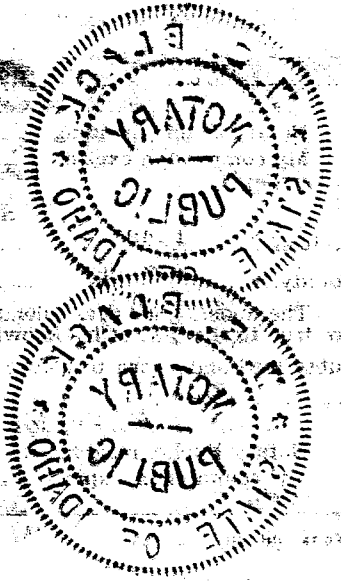
NOTARY
PUBLIC
IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 116
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED SEP 19 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Juliaetta
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Juliaetta
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): HERBERT
b. (Middle): CHARLES
c. (Last): WEBER

4. DATE OF DEATH (Month) (Day) (Year): 5 Sept 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 2 March 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Farm Machinery
11. BIRTHPLACE (State or foreign country): Kendrick, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Weber — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Elsie Comstock — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 531 16 5019
17. INFORMANT'S OWN SIGNATURE: Mamie Weber — ADDRESS: Juliaetta, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 20 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. obstructive emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO XXX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1963 *to* Aug, 1967, *that I last saw the deceased alive on* 15 Aug, 1967, *and that death occurred at* 12:05 AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. T. Fritzmann MD
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 9 Aug 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 5 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-18-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: K. H. Malcom — Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-376

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4094117
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED
SEP 19 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY in this place: 600
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Hulda	Elizabeth	Lundquist	Sept 5 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	widowed	Feb 8, 1879	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife		Alexandria, Minn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
August Anderson	Sweden	Emma Hagstrom	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-54-3682	x Melvin A. Lundquist	Moscow

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2043

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYELOGENOUS LEUKEMIA, ACUTE — INTERVAL BETWEEN ONSET AND DEATH: #3 Mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 19 59, *to* Sept 5, 1967, *that I last saw the deceased alive on* Sept 5, 19 67, *and that death occurred at* 12:30 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Moscow, Idaho	8 Sept 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept 8, 1967	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-18-67	Cheryl Ann Williams	Ronald Ward	E-30

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4095118
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

SEP 19 1967

1. PLACE OF DEATH a. COUNTY Latah 291 302	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Idaho 291 b. COUNTY Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow Bureau of Vital Statistics c. LENGTH OF STAY (In this place) 12 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital	d. STREET ADDRESS (If rural, give location) 115 North Hayes

3. NAME OF DECEASED (Type or Print)	a. (First) Floyd	b. (Middle) Willard	c. (Last) Nolan	4. DATE OF DEATH (Month) (Day) (Year) Sept. 6, 1067
5. SEX Male	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH April 10, 1904	9. AGE (In years last birthday) 63 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laber 06	10b. KIND OF BUSINESS OR INDUSTRY University of Idaho	11. BIRTHPLACE (State or foreign country) Harrison, Nebraska	12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James Nolan	BIRTHPLACE Keokuk, Iowa	14. MOTHER'S MAIDEN NAME Eva Morgareidge	BIRTHPLACE Sharon, Ohio	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-01-4771	17. INFORMANT'S OWN SIGNATURE Alice Nolan	ADDRESS Moscow, Idaho	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4928

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Congestive Heart failure	9-4-67
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Acute Myocarditis	9-4-67
DUE TO (c)	Acute Viral Pneumonia	9-4-67
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Subendocardial Ischemia Pyuria, Only One Kidney	

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION none

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* 9-28-44, 19__, *to* 9-8, 1967, *that I last saw the deceased alive on* 9-6, 1967, *and that death occurred at* 5:45 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 567 Joseph Wilson M.D.	23b. ADDRESS Moscow, Idaho	23c. DATE SIGNED 9-6-67	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial	24b. DATE Sept. 9, 1967	24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery	24d. LOCATION (City, town, or county) (State) Moscow Idaho
DATE REC'D BY LOCAL REG. 9-18-67	REGISTRAR'S SIGNATURE Cheryl Ann Williams	25. EMBALMER Max J. Malatta	LICENSE NO. E-519

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 21 1967

MAR 14 1968

OCT 5 1988

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 114096
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Near Potlatch
c. LENGTH OF STAY (in this place): few min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 95 A enroute Moscow 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 050
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emida
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Alfred
b. (Middle): Alfonso
c. (Last): Quincy

4. DATE OF DEATH (Month) (Day) (Year): September 8 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 5, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Equipment Operator
10b. KIND OF BUSINESS OR INDUSTRY: Benewah County
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Henry H. Quincy — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Margaret Jackson — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 533-01-9779
17. INFORMANT'S OWN SIGNATURE: Robert Short — ADDRESS: Emida, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Coronary insufficiency — 6-8 hrs
DUE TO (c): Coronary atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 8 1967 10:00 P.M., *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Rex Brooks 058 / M.D.
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: Sept. 22, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-12-1967
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: 9-29-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: L. Donald Ward
LICENSE NO.: E 380

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: SHORT'S CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

UCT 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 31 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 4 1990

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 0 9 1990

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 14097
Local Reg. No. 200
Reg. Dist. No.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 1-01 214
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 14 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home 329

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington 555
b. COUNTY: Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 434 5th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Albert
b. (Middle): (none)
c. (Last): Severson

4. DATE OF DEATH (Month) (Day) (Year): September 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): D
8. DATE OF BIRTH: Dec. 28, 1885
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist 10
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Vermillion, South Dakota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sever Severson — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Julia Roe — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 708-09-5590-A
17. INFORMANT'S OWN SIGNATURE: Alfred Severson — ADDRESS: Troy, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro-Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 36 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Diabetes Mellitus — years

331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1965, *to* Sept 17, 1967, *that I last saw the deceased alive on* Sept 16, 1967, *and that death occurred at* 2:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dr Adams, M.D. 001
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 9/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Idaho

DATE REC'D BY LOCAL REG.: 9-29-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Donald Ward
LICENSE NO.: E-380
FIRM NAME: Shorts Funeral Chapel, Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 9 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 4 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 124098
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 100
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Gritman Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 290
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): Herman
c. (Last): Gehrke

4. DATE OF DEATH (Month) (Day) (Year): Sept. 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 28, 1900
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired): Forman 08
10b. KIND OF BUSINESS OR INDUSTRY: State Highway Dept.
11. BIRTHPLACE (State or foreign country): Blue Earth, Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Gehrke — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Pauline Ardmann — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): 1920-1922 6
16. SOCIAL SECURITY NO.: 519-14-6070
17. INFORMANT'S OWN SIGNATURE: x Mrs Dolly Gehrke — ADDRESS: Genesee, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Arteriosclerotic Heart Dis. — yes.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* About 6:00 A.M. on Sept. 18, 1967, *19___ to ___, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at ___ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 — (Degree or title): M.D. Co. Coroner
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: Sept. 20, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Genesee City Cemetery
24d. LOCATION (City, town, or county): Genesee — (State): Idaho

DATE REC'D BY LOCAL REG.: 9-29-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Max J. Malutta
LICENSE NO.: E-519

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 21 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4099123
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED OCT 2 1967 Vital Statistics Bureau of Health

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 50 days 305
d. FULL NAME OF HOSPITAL OR INSTITUTION: Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 290 b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Potlatch
d. STREET ADDRESS (If rural, give location): 410 Spruce

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PAUL	HAROLD	TOBIN	Sept. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	4-21-1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Production Supt. 26	PFI Mill	Anoka, Minnesota	U. S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Patrick W. Tobin	Ireland	Elizabeth Larkin	Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW1 3	519-09-4900A	Ina B. Tobin	Potlatch, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Myocardial Infarction	5 Minutes
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Cardiovascular Disease	10 Years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	acute Pneumonitis w/Pleural Effusion Congestive Heart Failure - Mild	8 days 3 Mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 3, 1964, *to* Sept. 20, 1967, *that I last saw the deceased alive on* Sept 19, 1967, *and that death occurred at* 4:35 AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Nanis A. Biggerstaff, M.D.	225 Sixth St. Potlatch	9/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-22-1967	Moscow Cemetery	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-29-67	Cheryl Ann Williams	H. E. Kimball	E269

FIRM NAME: Kimball Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 22 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 7 1993

MAR 14 1997

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 124 4100
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 198 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 24 Minnesota
b. COUNTY: 555 Hennepin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Minneapolis
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print)
a. (First): Inga
b. (Middle): M.
c. (Last): Larsen

4. DATE OF DEATH (Month) (Day) (Year): Sept. 22, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 24, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Cook ~~[illegible]~~ 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Mathias Melvik — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Martha Ursim — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 469-28-9661
17. INFORMANT'S OWN SIGNATURE: X Morris C. Larsen — ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) metastatic adenocarcinoma 6 mo — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) primary in colon

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

1538

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1967, *to* Sept, 1967, *that I last saw the deceased alive on* 22 Sept, 1967, *and that death occurred at* 905 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE: J. S. Fritzmann (Degree or title) 057
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 25 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 9-29-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Max J. Malutta
LICENSE NO.: E-519

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4101 125
Local Reg. No. 200
Reg. Dist. No.

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
LENGTH OF STAY (In this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CLARENCE	HENRY	FRY	23 Sept. 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	19 Oct. 1886	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 64	Stock & Grain	Chico, Calif.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Solomon H. Fry	Loganport, Indiana	Louesa F. Lemm	Elenville, N.Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		519 09 4534	William Fry	Juliaetta, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4288

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19 71, *to* Sept 23, 1967, *that I last saw the deceased alive on* Sept 23, 1967, *and that death occurred at* 4:19 PM, *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D A Christensen	M D	Kendrick, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	23 Sept 1967	Lewis-Clark Memo. Gard.	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-30-67	Sheryl Ann Williams	W E Black — Malcom's Brower-Wann Memorial Chapel	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 128 4102
Local Reg. No. 200
Reg. Dist. No.

RECEIVED OCT 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 35 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah County Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 318 South Monroe

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Nellie	Chandler	Robinson	Sept. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	~~Widowed~~ 2	Jan. 7, 1892	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaker	Mayville, North Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas D. Moore	Monticello, Ind.	Emma P. Kleist	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-42-0119	Mrs. R. D. Cockrell	Tacoma, Washington

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Breast — 3 years
DUE TO (c) Cerebral Vascular Insufficiency — 3-4 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept. 15, 1967, *to* Sept. 29, 1967, *that I last saw the deceased alive on* Sept. 26, 1967, *and that death occurred at* 1:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Edward L. Doan 788 (Degree or title)	Professional Bldg. Moscow	10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	10-3-67	Hazen-Jaeger Crematory	Spokane Wn.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-67	Cheryl Ann Williams	Donald Ward ~~Shanks Funeral Chapel~~ Moscow, Idaho	E-380

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: OCT 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4103
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 137
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 37 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casabello Home 272

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 300
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Linda
b. (Middle): Melissa
c. (Last): Reynolds

4. DATE OF DEATH (Month) (Day) (Year): Sept. 1, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 30, 1874
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boulder, Colorado
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Perkins Allen — BIRTHPLACE: New Jersey
14. MOTHER'S MAIDEN NAME: Margaret Dickerson — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT'S OWN SIGNATURE: Salmon, Ida — ADDRESS: Myrtle Marsing

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cerebrovascular disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

331X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1965, *to* 9-1, 1967, *that I last saw the deceased alive on* 8-22, 19 67, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 263 (Degree or title) M.D.
23b. ADDRESS: Salmon Idaho
23c. DATE SIGNED: 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-5-67
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: 9-13-67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones — LICENSE NO. E 369

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 10 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4104
Local Reg. No. 698
Reg. Dist. No.

BIRTH NO.

RECEIVED SEP 22 1967

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 204
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 4 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 300
b. COUNTY: Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clayton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Rosa	Anna	Gossi	Sept. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	April 24, 1897	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
home 01		Clayton, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Budlong Carmen	Idaho	Rosa A. Carmen	Idaho Territory

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no	Mrs. Lothar Dreling	Clayton Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho-pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Hemorrhage — 1 year
DUE TO (c) Senility, cachexia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 19 61, *to* 9-7-, 19 67, *that I last saw the deceased alive on* 9-7-, 19 67, *and that death occurred at* 4: am *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Moore MD 369	Salmon, Idaho	9-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-9-67	Clayton	Clayton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-21-67	Viola E. Johnson	Delbert C. Jones	E 369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DD-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4105
Local Reg. No. 698
Reg. Dist. No.

RECEIVED
OCT 11 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 3 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Casabello Estate 272

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 27 Montana 555
b. COUNTY: Ravalli
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Stevensville
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Ada
b. (Middle):
c. (Last): Wood

4. DATE OF DEATH (Month) (Day) (Year): Sept. 23, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Nov. 13, 1912
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rancher 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Stevensville, Montana
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Ben Wood — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Myrtle Rosa Mize — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT'S OWN SIGNATURE: Harold Whiteside — ADDRESS: Stevensville, Mt

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

345X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 15, 1965, *to* Sept 23, 1967, *that I last saw the deceased alive on* Sept 23, 1967, *and that death occurred at* 11:15 Pm, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Roy W. Sinclair M.D. 474
23b. ADDRESS: Salmon Idaho
23c. DATE SIGNED: 9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-27-67
24c. NAME OF CEMETERY OR CREMATORY: Corvallis
24d. LOCATION (City, town, or county) (State): Corvallis, Montana

DATE REC'D BY LOCAL REG.: Oct 9th 67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones — LICENSE NO.: E 369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4106
Local Reg. No. 690
Reg. Dist. No.

RECEIVED
OCT 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 300 Lemhi 201
b. CITY OR TOWN near Salmon
c. LENGTH OF STAY (in this place) 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION Williams Creek Road 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 04 Arkansas
b. COUNTY 555
c. CITY OR TOWN Little Rock
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) James b. (Middle) Henry c. (Last) Sterner
4. DATE OF DEATH (Month) (Day) (Year): Sept. 25, 1967
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 14, 1929
9. AGE (In years last birthday): 37 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Butte, Montana
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: unknown — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): 1946 to 1952
16. SOCIAL SECURITY NO.: 517-26-5615
17. INFORMANT'S OWN SIGNATURE: Ellen Sterner ADDRESS: PortOrford, Ore

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation due to crushing injury to chest from car accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): road 06
21c. CITY, TOWN, OR TOWNSHIP: Salmon 13 (COUNTY) Lemhi 300 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car accident

22. I hereby certify that I attended the deceased from ____, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] (Degree or title) MD
23b. ADDRESS: Salmon Idaho
23c. DATE SIGNED: 9-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-28-67
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Oct 9th 67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4107
Local Reg. No. 690
Reg. Dist. No.

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clayton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Leo		Cominotti	Sept. 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	never married	Apr. 2, 1911	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
rancher 04		Clayton, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Antone Cominotti	Italy	Giovanna Pedrini	Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-22-8121	Fabio Cominotti	Clayton

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral degeneration

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Butane poisoning
resulting in severe brain damage
DUE TO (c) Accidental poisoning

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
XX	house trailer	13 Clayton, Idaho 190

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
May 15 - 62 m. 0		Living in house trailer-butane heat-leak in pipe

22. *I hereby certify that I attended the deceased from* mar, 19 64, *to* 9-27, 19 67, *that I last saw the deceased alive on* 9-27, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
263 MD	Salmon Idaho	10-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-2-67	Clayton	Clayton, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct-13-67	Viola E. Johnson	Delbert Jones	E369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-62021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 15 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4108
Local Reg. No. 653
Reg. Dist. No. 430

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
c. LENGTH OF STAY (in this place): Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home- Thorne Apartments

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 320
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LUCY	OLIVE	JONES	Sept. 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Feb. 22, 1882	85	7	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Buchanan Co., Hall Station, Mo.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John G. Coldiron	Kentucky	Nancy A. Barnes	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	no	518-60-3114	Wilma Sullivan	Shoshone, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary occlusion	30 Min
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1955 *to* 9-26, 1967, *that I last saw the deceased alive on* 9-26, 1967, *and that death occurred at* 2:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D. 386	Box 68 Shoshone Idaho	9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-29-1967	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-29-67	Francis M. Bergin	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4109
Local Reg. No. 42
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Green Rest Home 228

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 220
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Newdale
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): AFTON
b. (Middle): CAROLINE
c. (Last): BRIGGS LARSEN

4. DATE OF DEATH (Month) (Day) (Year): Sept., 2, 1967

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 28, 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Teton Basin, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Lorenzo Briggs — BIRTHPLACE: Salt Lake City, Ut.
14. MOTHER'S MAIDEN NAME: Mary Jane Naylor — BIRTHPLACE: Manchester, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-54-4802
17. INFORMANT'S OWN SIGNATURE: Wayne Larsen — ADDRESS: Newdale, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerosis — 2 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 8, 1966, *to* Sept. 2, 1967, *that I last saw the deceased alive on* Aug. 28, 1967, *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 537 AC Truxal, M.D.
23b. ADDRESS: Rexburg, Idaho
23c. DATE SIGNED: 9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5 Sept 67
24c. NAME OF CEMETERY OR CREMATORY: Teton-Newdale Cemetery
24d. LOCATION (City, town, or county) (State): Sugar City, RFD#1, Idaho

DATE REC'D BY LOCAL REG.: 9-11-67
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: M L Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

BIRTH NO. 67-8026

Certificate of Death

STATE OF IDAHO

SEP 21 1967

Bureau of Vital Statistics

State File No. 4110
Local Reg. No. 43
Reg. Dist. No. 630

1. PLACE OF DEATH

a. COUNTY: 331 Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho
b. COUNTY: 330 Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Thornton, Route 1
d. STREET ADDRESS (If rural, give location): RFD 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	William	David	Crowder	Sept.	5,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cauc.	Never Married	August 31, 1967			6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant 02		Rexburg, Idaho	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Lester Crowder	American Falls, Idaho	Jo Anne Russell	Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		David L. Crowder	Thornton Rt 1 Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 5 da

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-31- *, 19*67*, to* 9-5 *, 19*67*, that I last saw the deceased alive on* 9-5 *, 19*67*, and that death occurred at* 10⁴ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Leslie J. Peterson	413 MD	Rexburg Idaho	9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/6/67	Burton Cemetery	Rexburg, RFD. 1, Madison, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-6-67	Leonal Flamm	Russell Flamm	E 254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4111
Local Reg. No. 44
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 331 Madison 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 330
b. COUNTY Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sugar City
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) JAMES
c. (Last) LADLE

4. DATE OF DEATH (Month) (Day) (Year) September 15, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH November 2, 1877
9. AGE (In years last birthday) 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Farmington, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Ladle — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Susanna Trappett — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-36-3470
17. INFORMANT'S OWN SIGNATURE Ralph B. Ladle — ADDRESS Provo, Utah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9037

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 60 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Possible due to a fall (c lack of movement after) — 72 hours
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Extreme age

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Rest home. 13
21c. (CITY, TOWN, OR TOWNSHIP) Rexburg 13 **(COUNTY)** Madison 331 **(STATE)** Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept 8 67 Night m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Put fell while getting up from bed.

22. *I hereby certify that I attended the deceased from* June 2, 1959, *to* Sept 15, 1967, *that I last saw the deceased alive on* Sept 14, 1967, *and that death occurred at* 5:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE Blanche Passey 409 (Degree or title) 1
23b. ADDRESS Rexburg Idaho
23c. DATE SIGNED 9-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE Sept. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY Sugar City
24d. LOCATION (City, town, or county) Sugar City Madison (State) Idaho

DATE REC'D BY LOCAL REG. 9-18-67
REGISTRAR'S SIGNATURE Leona Flamm
25. EMBALMER Jerome H. Flamm — LICENSE NO. E347

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 10 1967

MAR 26 1968

APR 5 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4112
Local Reg. No. 45
Reg. Dist. No. 630

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 331 Madison
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 330
b. COUNTY Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Thornton
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First) FRANK
b. (Middle) ELMO
c. (Last) WEEKES

4. DATE OF DEATH (Month) (Day) (Year) September 17, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH November 12, 1923
9. AGE (In years last birthday) 43 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Sunnydell, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Cyril Weekes — BIRTHPLACE Sunnydell, Idaho
14. MOTHER'S MAIDEN NAME Ivy Allen — BIRTHPLACE Tetonia, Idaho
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War II 4
16. SOCIAL SECURITY NO. 529-26-8982
17. INFORMANT'S OWN SIGNATURE Margaret B. Weekes — ADDRESS Thornton, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

157X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pancreatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 1 year

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION October, 1966
19b. MAJOR FINDINGS OF OPERATION Intraductal Carcinoma - Pancreas - Metastatic
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1953, *to* Sept 17, 1967, *that I last saw the deceased alive on* Sept 17, 1967, *and that death occurred at* 6:05A *m., from the causes and on the date stated above.*

23a. SIGNATURE Blanche H Passey 409 (Degree or title)
23b. ADDRESS Rexburg Idaho
23c. DATE SIGNED 9-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/20/67
24c. NAME OF CEMETERY OR CREMATORY Sutton
24d. LOCATION (City, town, or county) Archer Madison (State) Idaho

DATE REC'D BY LOCAL REG. 9-19-67
REGISTRAR'S SIGNATURE Leona Flamm
25. EMBALMER Kenneth Flamm — LICENSE NO. E347

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 25 1967

SEP 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4113
Local Reg. No. 66
Reg. Dist. No. 450

RECEIVED SEP 29 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 1 wk.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hosp. 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 160
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elba
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Ollie
b. (Middle): Lloyd
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Aug. 30, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Dec. 25, 1898
9. AGE (In years last birthday): 68 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY: ******
11. BIRTHPLACE (State or foreign country): Elba, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: William H Lloyd - England
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Rachel Wilson - England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - -
16. SOCIAL SECURITY NO.: 519-34-4321
17. INFORMANT'S OWN SIGNATURE: Blanche Parish — ADDRESS: Elba, Id.

18. CAUSE OF DEATH 8254
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Atelectasis, bilateral, massive — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Automobile accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. See attached sheet.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident.
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Road 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Near Albion 160 Cassia Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug. 23 1967 m. 0
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Automobile accident

22. *I hereby certify that I attended the deceased from* Aug. 23, 19 67, *to* Aug. 30, 19 67, *that I last saw the deceased alive on* Aug. 30, 19 67, *and that death occurred at* 6:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G F Dalley 127 MD
23b. ADDRESS: 702 G St, Rupert Idaho
23c. DATE SIGNED: 9/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 9/2/67
24c. NAME OF CEMETERY OR CREMATORY: Elba Cemetery
24d. LOCATION (City, town, or county) (State): Elba, Idaho

DATE REC'D BY LOCAL REG.: 9-28-67
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: [signature]
LICENSE NO.: E 389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit, ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to:

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Patient: Ollie Lloyd

Concurrent Conditions:

Contusions, multiple, head, torso and extrimities.

Lacerations, multiple, superficial, head, arms and hands.

Fractures, left ribs, 2 through 10, on the lieft fractures, right ribs, 2 through 8.

Hemothorax, bilateral.
Hemoperitoneum, modertate.

Ulcer, acute, duodenal.

Contusion, small bowel.

Laceration of spleen with adjacent massive introsplenic and subcapsular hematoma.

Cerebral edema.

Hemorrhage, subarachnoid, focal, right lateral occipital lobe.

Perivascular, hemorrhage, focal, small, multiple, cerebellum, brain stem and cerebral hemispere.

Fracture, dislocation of left hip.

Certificate of Death

STATE OF IDAHO

State File No. 4114
Local Reg. No. 63
Reg. Dist. No. 150

BIRTH NO.

1. PLACE OF DEATH — SEP 22 1967
a. COUNTY Minidoka 340 — Bureau of Vital
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Near Paul Idaho — c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 825 west 700 north

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE unknown — b. COUNTY unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) unknown
d. STREET ADDRESS (If rural, give location) unknown

3. NAME OF DECEASED (Type or Print) — a. (First) b. (Middle) c. (Last): UNKNOWN WHITE ADULT MALE

4. DATE OF DEATH (Month) (Day) (Year): about 9-12-67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): unknown
8. DATE OF BIRTH: unknown
9. AGE (In years last birthday): About 60 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown
10b. KIND OF BUSINESS OR INDUSTRY: unknown
11. BIRTHPLACE (State or foreign country): unknown
12. CITIZEN OF WHAT COUNTRY? unknown

13. FATHER'S NAME: unknown — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): unknown — (If yes, give war or dates of service): unknown
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT'S OWN SIGNATURE: Robert E. Walk - Coroner — ADDRESS: Rupert

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) this man died of two gunsot wounds

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) from a 410 guage shot gun, one entered the left arm between the elbow and shoulder, the other entered the chest and shot off the upper part of the

DUE TO (c) heart.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): HOMICIDE 3
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): on farm land 02
21c. (CITY, TOWN, OR TOWNSHIP) near 73 (COUNTY) 340 Paul, Idaho Minidoka (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept 00 1967 m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive, 19—, to —, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* — m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert E. Walk (Degree or title): Coroner
23b. ADDRESS: 710 6th street Rupert Idaho
23c. DATE SIGNED: 9-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9-20-67
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: 9-22-67
REGISTRAR'S SIGNATURE: Mary Ellen Barker
25. EMBALMER: Charles D Parsons
LICENSE NO.: E-494

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4115
Local Reg. No. 67
Reg. Dist. No. 450

BIRTH NO.

RECEIVED SEP 28 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 340 Minidoka
b. CITY OR TOWN Rupert
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 340 Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
d. STREET ADDRESS (If rural, give location) 1005 J St.

3. NAME OF DECEASED (Type or Print) a. (First) Albert b. (Middle) Elmer c. (Last) Corless

4. DATE OF DEATH (Month) (Day) (Year) Sept. 16, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Jan 21, 1881

9. AGE (In years last birthday) 86
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert Edward Corless — BIRTHPLACE Salt Lake, Ut.

14. MOTHER'S MAIDEN NAME Polly Elmer — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) — — — —

16. SOCIAL SECURITY NO. 519-34-7024

17. INFORMANT'S OWN SIGNATURE A. W. Corless — ADDRESS Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4223

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial decompensation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 9-14-67

19b. MAJOR FINDINGS OF OPERATION Strangulated left direct inguinal hernia.

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 10, 1967, *to* Sept. 16, 1967, *that I last saw the deceased alive on* Sept. 16, 1967, *and that death occurred at* 12 p m., *from the causes and on the date stated above.*

23a. SIGNATURE H. W. Crawford, M.D. 740 (Degree or title)

23b. ADDRESS Rupert, Idaho

23c. DATE SIGNED 9-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/19/67

24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery

24d. LOCATION (City, town, or county) Heyburn, Idaho (State)

DATE REC'D BY LOCAL REG. 9-25-67

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER Hartsaye

LICENSE NO. E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4116
Local Reg. No. 65
Reg. Dist. No. 450

Certificate of Death

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 340 Minidoka 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
c. LENGTH OF STAY (in this place) 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) R.F.D. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340 b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
d. STREET ADDRESS (If rural, give location) R.F.D.

3. NAME OF DECEASED (Type or Print)
a. (First) James b. (Middle) Harland c. (Last) Sutton

4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Feb. 22, 1882
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Grantsville, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James T. Sutton — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Malinda Murch — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Sarah Hodskow — ADDRESS Heyburn, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute Myocardial failure

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c) arteriosclerotic Heart disease

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH: ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION none
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) none
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1948, 19__, *to* 1967, 19__, *that I last saw the deceased alive on* DOA, 19__, *and that death occurred at* during sleep, *from the causes and on the date stated above.*

23a. SIGNATURE R. T. Sutton 514 (Degree or title) MD
23b. ADDRESS Burley Ida
23c. DATE SIGNED 9/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 9/21/67
24c. NAME OF CEMETERY OR CREMATORY Oakley Cemetery
24d. LOCATION (City, town, or county) (State) Oakley, Idaho

DATE REC'D BY LOCAL REG. 9-26-67
REGISTRAR'S SIGNATURE Mary Ellen Carbon
25. EMBALMER [signature]
LICENSE NO. E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law; it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 9 1967 Bureau of Vital Statistics

State File No. 4117
Local Reg. No. 69
Reg. Dist. No. 45-0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 340 Minidoka 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. IF NOT IN CITY OR TOWN, LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 340 Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) Route 3

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle) 125
c. (Last) Chiopas

4. DATE OF DEATH (Month) (Day) (Year) 9-27-1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married

8. DATE OF BIRTH May 15 1886

9. AGE (In years Last birthday) 81
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY Sheep Ranch

11. BIRTHPLACE (State or foreign country) Makejonia Greece

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown
BIRTHPLACE Greece

14. MOTHER'S MAIDEN NAME unknown
BIRTHPLACE Greece

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 519-28-6150

17. INFORMANT'S OWN SIGNATURE Georgia Chiopas
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of lung.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiac decompensation.

INTERVAL BETWEEN ONSET AND DEATH: ?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1966, *to* Sept 27, 1967, *that I last saw the deceased alive on* Sept. 27, 1967, *and that death occurred at* 5 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE 340 H. W. Crawford, M. D. (Degree or title)

23b. ADDRESS Rupert, Idaho

23c. DATE SIGNED 10-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept 30 67

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) Rupert (State) Idaho

DATE REC'D BY LOCAL REG. 10-6-67

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER Robert C. Walk

LICENSE NO. 2294

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 8 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4118
Local Reg. No. 67
Reg. Dist. No. 450

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Minidoka 340 OCT 9 1967 000
b. CITY OR TOWN Rupert Bureau of Vital Statistics c. LENGTH OF STAY (If not in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 1217 H Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 1217 H Street

3. NAME OF DECEASED (Type or Print) a. (First) Hallie b. (Middle) c. (Last) Hall

4. DATE OF DEATH (Month) (Day) (Year) Sept 30 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Oct 25 1891

9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired housewife

10b. KIND OF BUSINESS OR INDUSTRY 01

11. BIRTHPLACE (State or foreign country) Louisburg Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Robert West BIRTHPLACE Louisburg Missouri

14. MOTHER'S MAIDEN NAME Rachel Lane BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 519-28-2309

17. INFORMANT'S OWN SIGNATURE Walk Hall ADDRESS Rupert

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 2 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 28, 1967, *to* Sept 30, 1967, *that I last saw the deceased alive on* Sept 29, 1967, *and that death occurred at* 6:30 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE 740 (Degree or title) W. W. Crawford, M.D. **23b. ADDRESS** Rupert, Idaho **23c. DATE SIGNED** 10-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** Oct 3 1967 **24c. NAME OF CEMETERY OR CREMATORY** Rupert Cemetery **24d. LOCATION** (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 10-6-67 **REGISTRAR'S SIGNATURE** Mary Ellen Carlson

25. EMBALMER Robert Walk **LICENSE NO.** E 294

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-69021

OCT 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 11 197

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4119
Local Reg. No. 210
Reg. Dist. No. 220

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 412
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
DURATION OF STAY (in this place): 12 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 180
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Greer
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ELSIE	MAY	STOCKARD	Aug. 12 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	white	widowed 2	Dec. 16, 1889	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Uniontown, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David McKinley	Iowa	Debra Cree	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	unknown	Kenneth D. Stockard	Orofino, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Undetermined (High fever — No cause found)	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Cardiac Decompensation	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

4344

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Don A. Stover	507 M.D.	939 Bryden LEWISTON, IDAHO	8/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Aug. 16, 1967	Riverside	Orofino Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
August 22, 1967	June M. Powell	Lyle A. Stutzmann	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Inform, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Stern

67-8082

RECEIVED

SEP 29 1967

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4120
Local Reg. No. 207
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 NezPerce 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 1day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) StJoseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 38 Oregon 555
b. COUNTY Umatilla
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pendleton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Inf. Daughter
b. (Middle) Mrs. Delors
c. (Last) Chance

4. DATE OF DEATH (Month) Aug. (Day) 25 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Aug 1967

9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR: Months 0, Days 0 — IF UNDER 24 HRS.: Hours ½, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Lewiston, Idaho.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Gary Chance — BIRTHPLACE Pendleton, Oregon

14. MOTHER'S MAIDEN NAME Delores Diety Glenmark — BIRTHPLACE North Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Mrs. Gary Chance — ADDRESS Pendleton. Ore.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

776X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature infant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Died 1/2 hr after

DUE TO (c) birth.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/25, 1967, *to* 8/25, 1967, *that I last saw the deceased alive on* 8/25, 1967 *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE W H Purce MD 420 (Degree or title)

23b. ADDRESS Lewiston Ida

23c. DATE SIGNED 9/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept 2,67

24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery

24d. LOCATION (City, town, or county) Lewiston, Idaho. (State)

DATE REC'D BY LOCAL REG. 9-1-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER Andrew F. Vassar — LICENSE NO. E315

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4121
Local Reg. No. 209
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH — SEP 29 1967
a. COUNTY 35 Nez Perce 306
b. CITY OR TOWN (If outside corporate limits, write township) Lewiston
Bureau of Vital Statistics
DURATION OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 603 Airway

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RICHARD	CALVIN	WINEGARDNER	27 August 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	14 Feb. 1891	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer & Mill 04	Stock/Grain & Lumber	Superior, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard Winegardner	Illinois	Harriet C. Wildes	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518 20 1063	Floyd C. Gallaher	Seattle, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

350X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 Week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Parkinson's Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Lewiston, Nez Perce, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__ *to* Aug ____, 1967, *that I last saw the deceased alive on* Aug 28, 1967, *and that death occurred at* 3:50 AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R M Glover MD	Lewiston, Idaho	29 Aug 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	29 Aug 1967	Lewis-Clark Memo. Gard.	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-6-67	Lynette Knott	L. E. DeBaun	E-295

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4122
Local Reg. No. 208
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

SEP 29 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nezperce 357 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 310
b. COUNTY: Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Craigmont
d. STREET ADDRESS (If rural, give location): 404 Halliday

3. NAME OF DECEASED (Type or Print)
a. (First): Phelma
b. (Middle): N.
c. (Last): Fisher

4. DATE OF DEATH (Month) (Day) (Year): Aug. 30 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Jan. 26, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Leeata, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: J. H. McDaniel — BIRTHPLACE: unknown Kansas
14. MOTHER'S MAIDEN NAME: Ethel Stover — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 56 0606
17. INFORMANT'S OWN SIGNATURE: Mc Jean Fisher — ADDRESS: Craigmont Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Suspected C.V.A

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinomas of Rectum

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to 8 30, 1967, that I last saw the deceased alive on 8/30, 1967 and that death occurred at 4 P m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Plummer 114 M.D.
23b. ADDRESS: 347 St Johns Way
23c. DATE SIGNED: 9 1 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem-burial 3
24b. DATE: 9-1-67
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-6-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Patrick Mahoney
LICENSE NO.: E421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Clovis Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUN 12 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

armstrong

Certificate of Death

STATE OF IDAHO

State File No. 4123
Local Reg. No. 204
Reg. Dist. No. 220

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 NezPerce 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 1 wk.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) Somerville Home

3. NAME OF DECEASED (Type or Print)
a. (First) Dena
b. (Middle)
c. (Last) Provost

4. DATE OF DEATH (Month) (Day) (Year) 8-30-67

5. SEX female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Nov.15,1878
9. AGE (In years last birthday) 88 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Minn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME E.F. Nelson — BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Caroline Anderson — BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 519-12-4731
17. INFORMANT'S OWN SIGNATURE Leo G. Provost — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 27, 1967, *to* Aug 30, 1967, *that I last saw the deceased alive on* Aug 30, 1967, *and that death occurred at* 1 30P *m., from the causes and on the date stated above.*

23a. SIGNATURE John Armstrong 013 (Degree or title) MD
23b. ADDRESS 307 St John's Way
23c. DATE SIGNED 9/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 9-1-67
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho.

DATE REC'D BY LOCAL REG. 8-31-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar — LICENSE NO.

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Boun...

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4124
Local Reg. No. 205
Reg. Dist. No. 220

BIRTH NO.

SEP 29 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 35 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 1 wk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 640-20th Ave

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ada		Dawald	Aug 30 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	White	Married 3	April 6 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife 01		Woodland, Wis.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
W.K.Gregary	England	X Rose Vince	Lancaster, Wis.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-34-6858 B	Merton Dawald	Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Thrombophlebitis

DUE TO (c) Varicosities

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/11/67, 19___, *to* 8/30/67, 19___, *that I last saw the deceased alive on* 8/30/67, 19___, *and that death occurred at* 11:46 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE	036 (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	M.D.	626 5th Ave. Lewiston	9/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-2-67	Normal Hill	Lewiston, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
8-31-67	Lynette Knott	Andrew F. Vassar	E315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 8 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 23 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. FEB 20 1991

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4125
Local Reg. No. 212
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

SEP 29 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF (If in this place): 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): Jess Apts.

3. NAME OF DECEASED (Type or Print)
a. (First): HENRY
b. (Middle): AUGUST
c. (Last): JESS

4. DATE OF DEATH (Month) (Day) (Year): 30 August 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 9 August 1879
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Builder/Invester 24
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Blue Hill, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Jess — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: AnnaOye — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 52 7879 JL
17. INFORMANT'S OWN SIGNATURE: Stanley O. Müller — ADDRESS: Lewiston, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Carcinoma of Stomach
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Carcinoma of Prostate

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 15, 1967, *to* Aug 30, 1967, *that I last saw the deceased alive on* Aug 30, 1967, *and that death occurred at* 5:55 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 507 L M Stover MD
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: Sept. 9, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-8-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L. E. DeBaun — Malcom's Brower-Wann Memo. Chapel
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4126
Local Reg. No. 206
Reg. Dist. No. 220

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 3304 - 10th Street

3. NAME OF DECEASED (Type or Print)
a. (First) EDWARD
b. (Middle) RAY
c. (Last) WILKINS

4. DATE OF DEATH (Month) 31 (Day) August (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH 18 Dec. 1951
9. AGE (In years last birthday) 15 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY Public School
11. BIRTHPLACE (State or foreign country) Mt. Pleasant, Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Eugene Wilkins — BIRTHPLACE Keeksburgh, Penna.
14. MOTHER'S MAIDEN NAME Celia Miller — BIRTHPLACE Laurelville, Penna.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 64 0681
17. INFORMANT'S OWN SIGNATURE Eugene Wilkins — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral contusion + hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 6 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile Injury — 6 hrs
DUE TO (c) ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Multiple laceration — 6 hrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-31-67, 19__, *to* 8-31-67, 19__, *that I last saw the deceased alive on* 8-31-67, 19__, *and that death occurred at* 2:40 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 325
23b. ADDRESS 324-5th St Lewiston Idaho
23c. DATE SIGNED 9-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 4 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery
24d. LOCATION (City, town, or county) (State) Mt.Pleasant, Westmoreland, Penna.

DATE REC'D BY LOCAL REG. 9-1-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER E. E. DeBaun — Maldom's Brower-Wann Memorial Chapel
LICENSE NO. E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4127
Local Reg. No. 213
Reg. Dist. No. 220

Certificate of Death

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (In this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 702 - 10th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) BESSIE
b. (Middle) CATHERINE
c. (Last) STARNES

4. DATE OF DEATH (Month) 1 (Day) Sept. (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 5 Nov. 1903
9. AGE (In years last birthday) 63 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Stony Creek, Tennessee
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME David M. Walsh — BIRTHPLACE Tennessee
14. MOTHER'S MAIDEN NAME Amanda Grandstaff — BIRTHPLACE Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 24 3539
17. INFORMANT'S OWN SIGNATURE J. B. Starnes — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atero Sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Not seen Prior to Death, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 7:00 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE J. P. Klein M.D. (Degree or title) 629
23b. ADDRESS Clarkston Wash
23c. DATE SIGNED 5 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 5 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 9-8-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER L. E. DeBaun Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4128
Local Reg. No. 211
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 350 Nez Perce 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 350
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
d. STREET ADDRESS (If rural, give location) 429 Preston

3. NAME OF DECEASED (Type or Print)
a. (First) Catherine
b. (Middle)
c. (Last) McConnell

4. DATE OF DEATH (Month) (Day) (Year) Sept. 6, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH May 24, 1883
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Marengo, Iowa
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Peter J. Zopf — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Ernistine Kniehl — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-60-5374J1
17. INFORMANT'S OWN SIGNATURE Mrs. Bernadette Sandberg — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

170 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of trunk, (Unoperated) with direct extension to chest and mediastinum

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

19a. DATE OF OPERATION None.
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 65, 19__, *to* Sept 6, 1967, *that I last saw the deceased alive on* Sept 4, 1966, *and that death occurred at* 7 a m., *from the causes and on the date stated above.*

23a. SIGNATURE 0220 Joseph E. Baldwin M.D. (Degree or title)
23b. ADDRESS 1522 17th St Lewiston Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Sept. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memorial Gardens
24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 9-8-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER V. Vassar
LICENSE NO. E 297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4129
Local Reg. No. 214
Reg. Dist. No. 220

RECEIVED SEP 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 319-5th Street 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 05 California
b. COUNTY: 555 S cramento
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sacramento
d. STREET ADDRESS (If rural, give location): no record

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Stanley	J.	Kane	Sept. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Nov. 6, 1899	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Ft. Collins, Colorado	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Kahn	Germany	Mertie Pegg	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	unknown	556-36-7351	[signature]	Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Artery Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: ½-1 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9- Sept., 1967, *to* 9- Sept., 1967, *that I last saw the deceased alive on* ——, 19—, *and that death occurred at* 2 38 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B R Stein	496 MD-1	Lewiston - Idaho	18 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
cremation	Sept. 12, 1967	Hazen & Jaeger	Spokane, Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-12-67	Lynette Knott	D. Vasser	E. 297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4130
Local Reg. No. 216
Reg. Dist. No. 220

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 29 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 836 1/2 Main Street, Apt. #2

3. NAME OF DECEASED (Type or Print)
a. (First): HARVEY
b. (Middle): P.
c. (Last): BEAVERS

4. DATE OF DEATH (Month) (Day) (Year): 12 Sept. 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 11 October 1898
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Boilmaker & Pipe Fitter 21
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Clinton, Arkansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James W. Beavers — BIRTHPLACE: Louisiana
14. MOTHER'S MAIDEN NAME: Mary E. McNabb — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 510 03 8576
17. INFORMANT'S OWN SIGNATURE: /ss/ Fern Beavers — ADDRESS: Northridge, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: moments

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): -------
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from ---------, 19--- to ---------, 19___, that I last saw the deceased alive on ---------, 19--, and that death occurred at 9:00 p m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Duclos 583 (Degree or title): NezPerce Co. Coroner 4
23b. ADDRESS: Lewiston Idaho
23c. DATE SIGNED: 14 Sept 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 16 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-18-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L. E. DeBaun — LICENSE NO.: E-295
Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 24 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 13 1974

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4131
Local Reg. No. 218
Reg. Dist. No. 220

Certificate of Death

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nezperce 306
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 250
b. COUNTY Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) 105 N Junction

3. NAME OF DECEASED (Type or Print)
a. (First) JAY
b. (Middle) VIRGIL
c. (Last) HARRIS

4. DATE OF DEATH (Month) (Day) (Year) September 13, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH April 16, 1919
9. AGE (In years last birthday) 48 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk 23
10b. KIND OF BUSINESS OR INDUSTRY Auto Parts
11. BIRTHPLACE (State or foreign country) Whitebird, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Claude M Harris — BIRTHPLACE Humeston, Iowa
14. MOTHER'S MAIDEN NAME Nellie Gibbs — BIRTHPLACE Humeston, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 18 3449
17. INFORMANT'S OWN SIGNATURE Ruth Davis — ADDRESS XX Joseph, Oregon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1992

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 3+ weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 Sept., 1967, *to* 13 Sept., 1967, *that I last saw the deceased alive on* 13 Sept., 1967, *and that death occurred at* 8 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE B R Stein 496 (Degree or title) MD 1
23b. ADDRESS Lewiston Idaho
23c. DATE SIGNED 20 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept 16, 1967
24c. NAME OF CEMETERY OR CREMATORY Prairieview
24d. LOCATION (City, town, or county) Grangeville, Idaho (State)

DATE REC'D BY LOCAL REG. 9-20-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Robert R Hansen — Robert R Hansen
LICENSE NO. E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

5 & 14

DUTIES:

NOV 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4132
Local Reg. No. 219
Reg. Dist. No. 220

RECEIVED
SEP 29 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 351 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1303 - 11th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) TRAUGOTT
c. (Last) BRAKER

4. DATE OF DEATH (Month) (Day) (Year) 17 September 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 22 February 1899
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Stock & Grain
11. BIRTHPLACE (State or foreign country) Wadena, Minnesota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wilhelm Braker — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Anna Thurmer — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 558 03 9098
17. INFORMANT'S OWN SIGNATURE Mrs William Braker — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH 334X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Heart Attack

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe Generalized Arteriosclerosis associated with at least
DUE TO (c) 2 Strokes & 1 Coronary

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's Sex

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 1966, *to* 6-6, 1967, *that I last saw the deceased alive on* 5-11-, 1967 *and that death occurred at* 3:50 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 114 (Degree or title)
23b. ADDRESS 347 St Johns Way
23c. DATE SIGNED 9/29

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 20 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 9-22-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER L E DeBaun
LICENSE NO. E-295
Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (*probably*) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4133
Local Reg. No. 217
Reg. Dist. No. 220

BIRTH NO.

SEP 29 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 wkd 30
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor Nuraing Home 3/2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 934 Bryden Ave.

3. NAME OF DECEASED (Type or Print): a. (First) MARY b. (Middle) LILLIAN (Haydon) c. (Last) PHYTHIAN

4. DATE OF DEATH: (Month) 17 (Day) September (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 3 April 1886

9. AGE (In years last birthday): 81 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Frankfort, Kentucky

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Haydon
BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Louisa Cox
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No record

17. INFORMANT'S OWN SIGNATURE: Mrs. Lillie Smith
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Inoperable carcinoma of sigmoid colon

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 28 Aug, 1967, *to* 17 Sept, 1967, *that I last saw the deceased alive on* 17 Sept, 1967, *and that death occurred at* 1:20 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David W. Stewart MD

23b. ADDRESS: 307 St Johns Ave

23c. DATE SIGNED: 18 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 19 Sept 1967

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memo. Gardens

24d. LOCATION (City, town, or county) (State): Billings, Yellowstone Co., Mont.

DATE REC'D BY LOCAL REG.: 9-18-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: L. E. DeBaun

LICENSE NO.: E-295

FIRM NAME: Maldom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 3 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4134
Local Reg. No. 220
Reg. Dist. No. 220

RECE'

Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 29 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: 555 Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 1278 Ash

3. NAME OF DECEASED (Type or Print)
a. (First): FRANCES
b. (Middle): E.
c. (Last): FROST

4. DATE OF DEATH (Month) (Day) (Year): September 19, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 10/12/1915
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress 06
10b. KIND OF BUSINESS OR INDUSTRY: Restaurant
11. BIRTHPLACE (State or foreign country): Santa Cruz, California
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Henry Pugh — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Altha Barber — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 568 22 2931
17. INFORMANT'S OWN SIGNATURE: Michael Frost — ADDRESS: Clarkston, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-11-64, 19__, *to* 9-19, 19 67, *that I last saw the deceased alive on* 9-19-67, 19__, *and that death occurred at* 12 N., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lussmon 114 — 23b. ADDRESS: 347 St Johns Way — 23c. DATE SIGNED: 9-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial 3
24b. DATE: 22 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 9-25-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: N C Merchant — LICENSE NO. FDS

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: MERCHANT FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 13 1968

MAY 15 1986

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4135
Local Reg. No. 226
Reg. Dist. No. 220

67-9227 BIRTH NO.

RECEIVED OCT 17 1967 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Nez Perce 35

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

c. LENGTH OF STAY (in this place): Life

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 405 628

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 35

b. COUNTY: Nez Perce 351

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

d. STREET ADDRESS (If rural, give location): 3414 - 16th Street

3. NAME OF DECEASED (Type or Print): a. (First) SIDNEY b. (Middle) LEVIRN c. (Last) DeBORD

4. DATE OF DEATH: (Month) (Day) (Year) 20 September 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 19 Sept 1967

9. AGE (In years last birthday): - - - - | IF UNDER 1 YEAR: Months - - | Days - - | IF UNDER 24 HRS.: Hours 5 | Min. 15

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Lewiston, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel D. DeBord — BIRTHPLACE: Weiser, Idaho

14. MOTHER'S MAIDEN NAME: Linda C. McDowell — BIRTHPLACE: Wendell, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Daniel De Bord — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7768

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept 20, 1967, *to* Sept 20, 1967, *that I last saw the deceased alive on* Sept 20, 1967, *and that death occurred at* 1:30 AM., *from the causes and on the date stated above.*

23a. SIGNATURE: Wm Baird 051 (Degree or title): MD

23b. ADDRESS: 1522 17th St

23c. DATE SIGNED: Sept 23

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 22 Sept, 1967

24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-29-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel — LICENSE NO.: E-295

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 1 2 2005

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4136
Local Reg. No. 223
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hosp. 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 250
b. COUNTY: Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Woodland
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Ora
b. (Middle): Ellen
c. (Last): Bacon

4. DATE OF DEATH (Month) (Day) (Year): Sept. 21 1967

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 17 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wife - Mother 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Guide Rock Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Austin George — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Sarah Jeanette Haskins — BIRTHPLACE: Guide Rock, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-60-5766
17. INFORMANT'S OWN SIGNATURE: Harold Bacon — ADDRESS: Woodland, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9037

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 9 da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fracture Right femur — 9 da

19a. DATE OF OPERATION: 9-12-67
19b. MAJOR FINDINGS OF OPERATION: Fracture of hip
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 01 Nursing home
21c. (CITY, TOWN, OR TOWNSHIP) 250 (COUNTY) (STATE): 13 Grange ville Idaho Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: 0
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: 2 fell

22. *I hereby certify that I attended the deceased from* 9-11, 1967, *to* 9-21, 1967, *that I last saw the deceased alive on* 9-21, 1967, *and that death occurred at* 3PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: R. C. Osborn 098 (Degree or title): MD
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 9-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Woodland Cem.
24d. LOCATION (City, town, or county) (State): Woodland Idaho

DATE REC'D BY LOCAL REG.: 9-27-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: W. C. Merchant — LICENSE NO.: FD 5

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Trenary Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4137
Local Reg. No. 221
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 616 - 10th Street

3. NAME OF DECEASED (Type or Print)
a. (First): EVERETT
b. (Middle): LESLIE
c. (Last): McNICHOLAS

4. DATE OF DEATH (Month) (Day) (Year): 21 Sept 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 6 January 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: Auto
11. BIRTHPLACE (State or foreign country): Connell, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas McNicholas — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW-1 3
16. SOCIAL SECURITY NO.: 518 01 1164
17. INFORMANT'S OWN SIGNATURE: Iona T McNicholas — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 1-2 minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c): Hypertension — 5 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 Sept 67 *19___, to* Sept 21 *, 19*67*, that I last saw the deceased alive on* 20 Sept *, 19*67*, and that death occurred at* 6:20 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Eugene J Baldwin 021
23b. ADDRESS: 636 5th Avenue Lewiston Ida
23c. DATE SIGNED: 22 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 23 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 9-25-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L E DeBaun — Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4138
Local Reg. No. 225
Reg. Dist. No. 220

Certificate of Death

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (If not in place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1424 Bryden Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) SENES ARTHUR ORTON
b. (Middle)
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) 23 September 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 25 June 1907
9. AGE (In years last birthday) 60 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber 21
10b. KIND OF BUSINESS OR INDUSTRY Co-Owner
11. BIRTHPLACE (State or foreign country) Byrnedale, Penna.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Orton — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Annie Alsop — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW-2 4
16. SOCIAL SECURITY NO. 211 03 7316
17. INFORMANT'S OWN SIGNATURE X Senes D. Orton — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hy PENTENSIVE Heart DISEASE — INTERVAL BETWEEN ONSET AND DEATH 2yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* AUG 17, 1967, *to* SEPT 23, 1967, *that I last saw the deceased alive on* AUG 29, 1967, *and that death occurred at* 11:20 AM, *from the causes and on the date stated above.*

23a. SIGNATURE John Armstrong — (Degree or title) 01B MD 1
23b. ADDRESS 307 St John's Way
23c. DATE SIGNED 9/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 26 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 9-29-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER W. E. Black — Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: OCT 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4139
Local Reg. No. 222
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH — SEP 29 1967
a. COUNTY: Nez Perce 351 — 314
b. CITY OR TOWN: Lewiston — Bureau of Vital Statistics — LENGTH OF STAY (in this place): 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION: St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351 — b. COUNTY: NezPerce
c. CITY OR TOWN: Lewiston
d. STREET ADDRESS (If rural, give location): 844 Main Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WOLFORD	R.	JOHNSTON	23 Sept 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married 7	18 March 1890	77		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ordained Minister 18	Ame. Sun. Sch. Union	Baxter, Kentucky	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Amos J. Johnson	Kentucky	Minty Long	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW-I 3	518 40 8752	Rev. Keith Dimple	Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. post-op: Retropubic prostatectomy

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9/13/67	Benign hypertrophic prostate gland	YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 9/7/1967, *to* 9/23, 1967, *that I last saw the deceased alive on* 9/22, 1967, *and that death occurred at* 7:15 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. J. Black, M.D.		307 St John Way Lewiston Idaho	9/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	26 Sept 1967	Johnson Family Cemetery	Baxter, Harlan Co., Kentucky

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-25-67	Lynette Knott	W E Black — Maldom's Brower-Wann Memorial Chapel	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 17 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4140
Local Reg. No. 224
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY NezPerce 351 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351 b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 840 Bryden Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ANNA	GENTRY	SCHROEDER	25 Sept 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	17 April 1896	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	North, Carolina, Jefferson	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Gentry	N. Car.	Celia Greene	N. Car.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 36 1354B	Bert L Broeder	Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 474X Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Laryngitis.
DUE TO (c) Meningeal infection?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senile Dementia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1952, 19__, *to* Sept 25, 1967, *that I last saw the deceased alive on* Sept 24 1967, *and that death occurred at* 5:45 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ron Glover MD. 507	939 Bryden - LEWISTON, IDAHO	9/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	29 Sept 1967	Lewis-Clark Memo. Gard.	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-29-67	Lynette Knott	L. E. DeBaun — Maldom's Brower-Wann Memorial Chapel	E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 17 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4141
Local Reg. No. 227
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nezperce 351 309
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 9days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1139 Bryden

3. NAME OF DECEASED (Type or Print)
a. (First): Samuel
b. (Middle): C.
c. (Last): Laird

4. DATE OF DEATH (Month) (Day) (Year): Sept. 26 1967

5. SEX: m.
6. COLOR OR RACE: W.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct. 18, 1876
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: David Laird — BIRTHPLACE: Ky.
14. MOTHER'S MAIDEN NAME: Jennie Carlisle — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 60 9376T
17. INFORMANT'S OWN SIGNATURE: Mrs. Wm Gray — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO (c) Infirmities of age

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-19, 1967, *to* 9-26, 1967, *that I last saw the deceased alive on* 9-26, 1967, *and that death occurred at* 4:10 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. M. Stover MD 507
23b. ADDRESS: 939 Bryden LEWISTON, IDAHO
23c. DATE SIGNED: 9-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 28 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston Idaho

DATE REC'D BY LOCAL REG.: 10-2-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: K.H. Malcom — LICENSE NO.: E 376
Malcom Brower-Wann Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4142
Local Reg. No. 230
Reg. Dist. No. 220

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) [redacted]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1524 - 9th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE
b. (Middle)
c. (Last) LAWRENCE

4. DATE OF DEATH (Month) (Day) (Year) September 30, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 30, 1908
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Worker 17
10b. KIND OF BUSINESS OR INDUSTRY Lumbering
11. BIRTHPLACE (State or foreign country) Anatone, Washington
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME Charles Lawrence — BIRTHPLACE Unk
14. MOTHER'S MAIDEN NAME Annie Kiesecker — BIRTHPLACE Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 24 4076
17. INFORMANT'S OWN SIGNATURE Mrs. Sylvan Kuack — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: a few hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Anterior deleter heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Bronchopneumonia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-30, 1967, *to* 9-30, 1967, *that I last saw the deceased alive on* 9-30, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 152 (Degree or title) The Eastwood Mt. 1
23b. ADDRESS Lewiston Idaho
23c. DATE SIGNED 10-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial 3
24b. DATE 2 Oct. 1967
24c. NAME OF CEMETERY OR CREMATORY Vineland Cemetery
24d. LOCATION (City, town, or county) (State) Clarkston, Washington

DATE REC'D BY LOCAL REG. 10-9-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER W. C. Merchant
LICENSE NO. FD 5

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: MERCHANT FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMA[illegible]
   Inclusi[illegible]
   the fact[illegible]

2. THE [illegible]
   of th[illegible]

3. THE R[illegible]
   Includi[illegible]

PENALTIES: [illegible]

(a) Know[illegible]

(b) Negle[illegible]
   dispo[illegible]

(c) Remo[illegible]
   from th[illegible]

(d) Alter[illegible]

STATEMENT OF [illegible]

Special [illegible]
city or to[illegible]
occurring [illegible]
be stated. [illegible]

STATEMENT OF [illegible]

Regardless [illegible]

COMPLETE ALL [illegible]
less than one [illegible]
county or sta[illegible]

IDAHO CODE [illegible]

The person [illegible]
the informa[illegible]

The stat[illegible]
person acting [illegible]

The medi[illegible]
deceased, w[illegible]
of the day [illegible]
course of dis[illegible]
contributory [illegible]
only symptom[illegible]
burial or re[illegible]
registrar [illegible]
definition [illegible]
in stating [illegible]
either dis[illegible]
stated, and [illegible]

ADDITIONAL [illegible]

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4143
Local Reg. No. 228
Reg. Dist. No. 220

BIRTH NO.

OCT 17 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 405
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 5 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 35
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1813 - 14th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	TRU-DEE	BELLE	MARVEL	30 Sept. 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	18 Nov. 1951	15				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	Public School	Lewiston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wilfred Marvel	Lewiston, Ida.	Ernestine Williams	Lewiston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 64 2204	Ernestine Y. Marvel	Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	8254 Massive brain injury	3 hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-31-67	Tracheotomy, Tube Thoracotomy (Left)	YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	Street 04	Lewiston 35 Nezperce Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
10		Car accident (passenger

22. *I hereby certify that I attended the deceased from* 9-30, 1967, *to* 9-30, 1967, *that I last saw the deceased alive on* 9-30, 1967, *and that death occurred at* 9:10 PM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John F. Bassin M.D. 028	347 St Johns Way Lewiston Idaho	10-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	3 Oct. 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-4-67	Lynette Knott	K. H. Malcom Malcom's Brower-Wann Memorial Chapel	E-276

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4144
Local Reg. No. 19
Reg. Dist. No. 530

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 21 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Oneida 360 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Oneida Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 360
b. COUNTY: Oneida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad
d. STREET ADDRESS (If rural, give location): 222 South 1st West St.

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): LAWRENCE
c. (Last): HESS

4. DATE OF DEATH (Month) (Day) (Year): Sept. 4, 1967

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Jan. 10, 1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: agriculture
11. BIRTHPLACE (State or foreign country): Farmington, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. Hess — BIRTHPLACE: Farmington, Ut.
14. MOTHER'S MAIDEN NAME: Sarah Amy King — BIRTHPLACE: So. Weber, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: Marguerite Mills — ADDRESS: Malad, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1) Senility & General Debility — INTERVAL BETWEEN ONSET AND DEATH: Prog. cpm.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
2) Prostate, Carcinoma of
3) Vertebral Collapse — probably Metastatic Malignancy — Sev. Yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/21, 1967, *to* 9/4, 1967, *that I last saw the deceased alive on* 9/4, 1967, *and that death occurred at* 1:15P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph F. Maby 314 MD
23b. ADDRESS: Malad, Idaho
23c. DATE SIGNED: 9/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: St. John Cemetery
24d. LOCATION (City, town, or county) (State): Oneida County, Idaho

DATE REC'D BY LOCAL REG.: Sept. 18-1967
REGISTRAR'S SIGNATURE: Ruth G. Swuten
25. EMBALMER: Raymond H. Benson
LICENSE NO.: E-351

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Benson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 19 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 5 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4145
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

RECEIVED OCT 6 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Owyhee 370
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Hammett
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Indian Hill Project 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 370
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Indian Cove
d. STREET ADDRESS (If rural, give location): Indian Cove

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) CLINE c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year): Sept. 13, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 7, 1913

9. AGE (In years last birthday): 54 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Detroit, Michigan

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 383-03-5637

17. INFORMANT'S OWN SIGNATURE: Mrs. Lorine Smith
ADDRESS: Indian Cove

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Extreme Shock — INTERVAL BETWEEN ONSET AND DEATH: Seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Traumatic injuries to right and left shoulders, chest and back.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Farm 04

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rural 13 Hammett, Owyhee, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Sept. 13, 1967 4 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Became entangled in power take-off machinery.

22. *I hereby certify that I attended the deceased from* Did not see alive. *, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Andrew Warfield 583 (Degree or title): Coroner 4

23b. ADDRESS: Homedale, Idaho

23c. DATE SIGNED: 9/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/15/67

24c. NAME OF CEMETERY OR CREMATORY: Glenn Rest Cemetery

24d. LOCATION (City, town, or county) (State): Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG.: Sept 25-67

REGISTRAR'S SIGNATURE: Mary Sullivan

25. EMBALMER: Arthur Smith

LICENSE NO.: E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

OCT 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 28 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 5 1981

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4146
Local Reg. No. 392
Reg. Dist. No. Homedale-Marsing

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 370 Owyhee
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Oreana
c. LENGTH OF STAY (in this place) 106 6 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 30 mi. so. of Oreana, Ida.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 370 b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Oreana
d. STREET ADDRESS (If rural, give location) 30 mi. so. of Oreana, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) Emil b. (Middle) (NMN) c. (Last) West

4. DATE OF DEATH (Month) (Day) (Year) Sept. 22, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH April 4, 1907

9. AGE (In years last birthday) 60 IF UNDER 1 YEAR Months 5 Days 18 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ranch-hand 04

10b. KIND OF BUSINESS OR INDUSTRY ranching

11. BIRTHPLACE (State or foreign country) Unknown

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 504-07-7135

17. INFORMANT'S OWN SIGNATURE Leonard C. Flahiff ADDRESS Funeral Director

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Immed.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?

22. *I hereby certify that I ~~attended the deceased from~~ investigated only on ____, 19__, to Sept. 23, 1967, that I last saw the deceased alive on ____, 19__, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE Andrew Warfield 583 (Degree or title) Coroner 4

23b. ADDRESS Homedale Idaho

23c. DATE SIGNED Sept. 27 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY Marsing-Homedale

24d. LOCATION (City, town, or county) Homedale, (State) Idaho

DATE REC'D BY LOCAL REG. Sept. 27 '67

REGISTRAR'S SIGNATURE Andrew Warfield

25. EMBALMER Leonard C. Flahiff

LICENSE NO. E-481

FIRM NAME: Homedale's Flahiff Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4147
Local Reg. No. 392
Reg. Dist. No. Marsing-Homedale

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Owyhee 390 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Homedale Nursing Home 305

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 390 b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing
d. STREET ADDRESS (If rural, give location): P. O. Box 364

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Walter	W.	Morrow	Sept. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Jan. 15, 1883	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29		Larry City, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marion Morrow	Unknown	Mary Derringer	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	483-07-1496	x Margaret M. Morrow	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 20 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Bronchitis — 5o

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Vascular Dis 25 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* Sept, 1967, *that I last saw the deceased alive on* Sept, 1967, *and that death occurred at* 11:30 Am., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. L. Poulsen 651	M.D.	Caldwell Idaho	3 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 3, 1967	Marsing-Homedale Cemetery	Marsing, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 6 '67	Andrew Warfield	Merville O Davis	E-399

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23e and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4148
Local Reg. No. 50
Reg. Dist. No. 330

Certificate of Death

RECEIVED
SEP 15 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 6 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt 1 Payette Valley Fruit Co.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 38 Oregon 555 b. COUNTY Multnomah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Portland
d. STREET ADDRESS (If rural, give location) 2402 2nd S.E. 1070 th.

3. NAME OF DECEASED (Type or Print)
a. (First) Amos b. (Middle) Melvin c. (Last) Smyder

4. DATE OF DEATH (Month) (Day) (Year) Sept. 5 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 20 1913
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor 04
10b. KIND OF BUSINESS OR INDUSTRY Farmer
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Lanore Snyder — ADDRESS Payette Auto Court Payette

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Scleratic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I* ~~attended the deceased from~~ Investigated *to* _____, ~~I last saw the deceased~~ *alive on* Sept 5 *19*67, *and that death occurred at* 9:45 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE Hardy H Jackson 583 (Degree or title) County Coronor 4
23b. ADDRESS 112½ N. 8th Payette, Ida
23c. DATE SIGNED 9/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/7/67
24c. NAME OF CEMETERY OR CREMATORY Riverside
24d. LOCATION (City, town, or county) (State) Payette Idaho

DATE REC'D BY LOCAL REG. 9/7/67
REGISTRAR'S SIGNATURE Roberta E Shaffer
25. EMBALMER Donald F Brown — Donald F. Brown
LICENSE NO. E-408

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Chapel of the Roses

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 26 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 28 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4149
Local Reg. No. 57
Reg. Dist. No. 330

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural New Plymouth
c. LENGTH OF STAY (in this place): 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1½ Mi. South New Plymouth 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 380
b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural New Plymouth
d. STREET ADDRESS (If rural, give location): 1½ Mi. South of New Plymouth

3. NAME OF DECEASED (Type or Print)
a. (First): Thomas
b. (Middle): Franklin
c. (Last): Johnson

4. DATE OF DEATH (Month) (Day) (Year): September 13, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: December 1, 1902
9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months - Days --
IF UNDER 24 HRS.: Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farm Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Van Buren, Arkansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Holland Johnson
BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Mary Gentry
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): - -
16. SOCIAL SECURITY NO.: 445-03-5509
17. INFORMANT'S OWN SIGNATURE: Lesala Johnson
ADDRESS: Route #0 New Plymouth, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

451X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Dissecting Aneurysm of Ascending Aorta with rupture into pericardial cavity.
INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I ~~attended the deceased from~~* Investigated ~~to~~ ~~that I last saw the deceased alive~~ *on* Sept. 13, 1967 *and that death occurred at* 9:45 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Hardy H Jackson 583 (Degree or title): Coroner 4
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 9/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Park View Cemetery
24d. LOCATION (City, town, or county) (State): New Plymouth Idaho

DATE REC'D BY LOCAL REG.: 9-15-1967
REGISTRAR'S SIGNATURE: Robert E. Shaffer
25. EMBALMER: Marvin R. Heikkila
LICENSE NO.: E-515

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shaffer Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4150
Local Reg. No. 52
Reg. Dist. No. 330

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
STATE OF IDAHO
SEP 25 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 380 Payette — 108
b. CITY OR TOWN: Payette
c. LENGTH OF STAY (in this place): 8 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1520 Center Ave. — 600

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — 380
b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1520 Center Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	William	Edwin	Nelson	September 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Divorced — 4	Nov. 11, 1891	75	—	—	—	—

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Produce Manager — 26	Fruit and Canning	Neenah, Wisconsin	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Martin H. Nelson	Wisconsin	Helen Cornelia	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I — 3	535-09-1397	Mina A. Gahringer	Wenatchee, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis, acute — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Resection of colon for CA Aug 67 (Adenocarcinoma)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - - - - -	- - - - - - - - - -	- - - - - - - - - - - - - - - - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
- - - - - - - - - - m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	- - - - - - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* 1959, 19____, *to* 9-16-67, 19____, *that I last saw the deceased alive on* 9-14-67, 19____, *and that death occurred at* 11:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 574	M.D.	Payette, Idaho	9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 20, 1967	Riverside Cemetery	Payette, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-19-67	Robert E. Shaffer	Keith M. Jensen	E-517

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4151
Local Reg. No. 53
Reg. Dist. No. 330

BIRTH NO.

RECEIVED SEP 25 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 380 Payette 206
b. CITY OR TOWN Payette
c. LENGTH OF STAY (in this place) 6 months
d. FULL NAME OF HOSPITAL OR INSTITUTION Payette Valley Sanitarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 1040 N 9th

3. NAME OF DECEASED (Type or Print): a. (First) Henry; b. (Middle) George; c. (Last) Sick

4. DATE OF DEATH (Month) (Day) (Year): September 21, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: February 11, 1875

9. AGE (In years last birthday): 92
IF UNDER 1 YEAR: Months - Days -
IF UNDER 24 HRS.: Hours - Min. - -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Germany

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Heinrich Sick
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Matilda Diestel
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service) - -

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Elisabeth D. Campbell
ADDRESS: 8470 Fauntleroy Pl. S.W. Seattle, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4290

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease with failure — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility — 24 hrs
DUE TO (c) Fracture left hip — 25 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Bladder neck obstruction and supra-pubic catheter — 4 months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) —m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1961, 19____, *to* 9-21-67, 19____, *that I last saw the deceased alive on* 9-21-67, 19____, *and that death occurred at* 11:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE 574 (Degree or title) M.D.

23b. ADDRESS: Payette, Idaho

23c. DATE SIGNED: 9/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 23, 1967

24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery

24d. LOCATION (City, town, or county) (State): Payette, Idaho

DATE REC'D BY LOCAL REG.: 9/22/67

REGISTRAR'S SIGNATURE: Roberta E. Shaffer

25. EMBALMER: Keith M. Jensen

LICENSE NO.: E-517

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4152
Local Reg. No. 13
Reg. Dist. No. 500-602

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 4 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls 306
c. LENGTH OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rockland
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) DARWIN
b. (Middle) ARTHUR
c. (Last) ANDERSEN

4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 1
8. DATE OF BIRTH May 25, 1944
9. AGE (In years last birthday) 23 — IF UNDER 1 YEAR Months 3 Days 29 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) American Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur E. Andersen — BIRTHPLACE Rockland, Idaho
14. MOTHER'S MAIDEN NAME Lucille Clausen — BIRTHPLACE Rockland, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-56-3182
17. INFORMANT'S OWN SIGNATURE x Arthur Andersen — ADDRESS Rockland, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bilateral bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes mellitus and coma — 6 hours
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Renal impairment & blindness (due to diabetes mellitus — 3 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1960, *to* Sep 24, 1967, *that I last saw the deceased alive on* Sep 23, 1967, *and that death occurred at* 4:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE F. L. Harms, 203 M.D. (Degree or title)
23b. ADDRESS American Falls, Idaho
23c. DATE SIGNED 9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial 3
24b. DATE 9-27-67
24c. NAME OF CEMETERY OR CREMATORY Valley View Cemetery
24d. LOCATION (City, town, or county) (State) Rockland, Idaho

DATE REC'D BY LOCAL REG. 10-2-67
REGISTRAR'S SIGNATURE Colleen Hoofield
25. EMBALMER H. L. Davis — LICENSE NO. E-253

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4153
Local Reg. No. 14
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Power 390
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls 305
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rockland
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
SARAH	HORN	HASKELL	Sept.	28,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Jan. 31, 1893	74	7	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Sublett, Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel Horn	Utah	Persis Mores Chambers	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-40-2947B	Raymond Haskell	Rockland, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer Stomach — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-12-66, 19___, *to* 9-28-67, 19___, *that I last saw the deceased alive on* 9-28-67, 19___, *and that death occurred at* 5:45 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	American Falls, Idaho	10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial	10-2-67	Valley View Cemetery	Rockland Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-3-67	Callen Hadfield	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: OCT 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended

Certificate of Death

STATE OF IDAHO

State File No. 4154
Local Reg. No. 77
Reg. Dist. No. 142

BIRTH NO.

RECEIVED OCT 6 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 402 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
d. STREET ADDRESS (If rural, give location) 414 Park Ave.

3. NAME OF DECEASED (Type or Print) a. (First) VIRGIL b. (Middle) A. c. (Last) TRIPP

4. DATE OF DEATH (Month) (Day) (Year) Sept. 1, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Mar. 3, 1892
9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Bank Examiner
10b. KIND OF BUSINESS OR INDUSTRY 19 Banking
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME A.H. Tripp
BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Sally Clyne
BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 521-05-9797
17. INFORMANT'S OWN SIGNATURE Mrs. Virgil A. Tripp
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute, myocardial infarction — 34 hours
DUE TO (c) Coronary arteriosclerosis — unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
acute pulmonary edema and Cardiogenic shock.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 31, 1967, *to* Sept. 1, 1967, *that I last saw the deceased alive on* Sept. 1, 19 67 *and that death occurred at* 11:37 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title) 6725 — 23b. ADDRESS Wallace — 23c. DATE SIGNED 7 Sept 1967

24a. BURIAL-CREMATION-REMOVAL (Specify) Burial
24b. DATE Sept. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg, (State) Idaho

DATE REC'D BY LOCAL REG. 10-3-67
REGISTRAR'S SIGNATURE
25. EMBALMER Robert J. Ross
LICENSE NO. E-497

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 77
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Providence Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton
d. STREET ADDRESS (If rural, give location): 414 Park Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): VIRGIL
b. (Middle): A.
c. (Last): TRIPP

4. DATE OF DEATH (Month) (Day) (Year): Sept. 1, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Mar.3, 1892
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Bank Examiner
10b. KIND OF BUSINESS OR INDUSTRY: Banking
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: A.H. Tripp — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Sally Clyne — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 521-05-9797
17. INFORMANT'S OWN SIGNATURE: Mrs. Virgil A. Tripp — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Acute Myocardial Infarction — 34 hrs
DUE TO (c) Coronary arteriosclerosis — unknown

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Acute Pulmonary edema + Cardiogenic Shock

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 31 Aug, 1967, *to* 1 Sept, 1967, *that I last saw the deceased alive on* 1 Sept, 1967, *and that death occurred at* 11:37 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: William Nhere (Degree or title) M.D.
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 7 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept.5,1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: Sept 7,1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Robert G. Ross — LICENSE NO. E-497

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: MAISEL FUNERAL CHAPEL

DUTIES:

SEP 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 6 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4155
Local Reg. No. 57 56
Reg. Dist. No. 140

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 402 Shoshone
b. CITY OR TOWN Wallace
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 402 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location) Gem Hotel #16

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	D	BRUSTOS	Sept, 1, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	White	W	3-1-1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00	Bunker Hill Co.	Greece	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James D. Brustos		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	536-05-9688	Hospital Records	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Coronary Sclerosis + Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Several years

DUE TO (c) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: Several years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-1, 1967, *to* 9-1, 1967, *that I last saw the deceased alive on* 9-1, 1967, *and that death occurred at* 7:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. M. Peterson, M.D.	Wallace, Idaho	9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-11-67	Riverside Park	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 7, 1967	Hale Cornell	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Wabd Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 15 1967 Bureau of Vital Statistics

State File No. 4156
Local Reg. No. 76
Reg. Dist. No. 1-3

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 401 b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 12½ East Portland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Walter	J.	Olexer	Sept. 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	Divorced 4	Sept. 9, 1908	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	Hazelton, Pennsylvania	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Olexer	Unknown	Anna Maxine	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No None	543-03-0244	Bunker Hill Records	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Myocardial Infarction	7-8 hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic heart disease	1 year
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept 6, 1967, *to* Sept 6, 1967, *that I last saw the deceased alive on* Sept 6, 1967, *and that death occurred at* 6:25 p m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Orland B. Scott MD 461 (Degree or title)	Kellogg Idaho	9/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 11, 1967	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-12-67		Donald Maisel	452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 1 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4157
Local Reg. No. 57
Reg. Dist. No. 140

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn
c. LENGTH OF STAY (If outside this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 495
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn
d. STREET ADDRESS (If rural, give location) 1023 Larch Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Phil		De Lange	Sept. 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	2-25-1883	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mining & Farming	Retired	Belgium	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-38-9002A	Ann Lange Fiedler	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Gunshot Wound of Head — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide	East of Gun Club on City	Osburn, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
9-12-67 about 10:30 a.m.		Shot himself

22. *I hereby certify that I attended the deceased from* 9-12, 1967, *to* 9-12, 1967, *that I last saw the deceased alive on* 9-12, 1967, *and that death occurred at* about 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
T. M. Peterson, M. D.	MD	Wallace, Idaho	9-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 15-67	Restlawn Park	Couer D Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 15, 1967	Dale Cornell	Dale L. Cornell	E 406

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: CORNELL'S Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 4 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4158
Local Reg. No. 60
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 300 Shoshone 301
b. CITY OR TOWN Clarkia
c. LENGTH OF STAY (in this place) -1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) on road near Clarkia 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 050
b. COUNTY Benawah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harrison
d. STREET ADDRESS (If rural, give location) rural

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle) Squire
c. (Last) Williams

4. DATE OF DEATH (Month) (Day) (Year) September 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	April 9, 1891	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farming 84	self employed	Moscow, Idaho	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Williams	no record	Emma Rowland	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	536-07-8846	Esther S. Williams	Harrison, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 19___, *to* Sept 13, 1967, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. D. Thurston 533	MD	St. Maries, Idaho	9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Sept. 16, 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept. 23, 1967	Hale Harnell	V. Vassar	E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 6 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4159
Local Reg. No. 58
Reg. Dist. No. 140

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Shoshone 402

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace

LENGTH OF STAY (in this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 400

b. COUNTY: Shoshone

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Osburn

d. STREET ADDRESS (If rural, give location): 209 Larch Street

3. NAME OF DECEASED (Type or Print)

a. (First): Lola

b. (Middle):

c. (Last): Lomas

4. DATE OF DEATH: (Month) Sept. (Day) 13 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 18, 1922

9. AGE (In years last birthday): 45

IF UNDER 1 YEAR: Months / Days

IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Kansas City, Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Calvin Hackler

BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Cristol Beath

BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 513-16-7074

17. INFORMANT'S OWN SIGNATURE: Vera O Lomas

ADDRESS:

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cachexia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Multiple Sclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Months / Years: Years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* March, 1956, *to* Sept. 13, 1967, *that I last saw the deceased alive on* Sept. 12, 1967, *and that death occurred at* 6:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS: Box 200 Wallace, Idaho

23c. DATE SIGNED: 9-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept 16-67

24c. NAME OF CEMETERY OR CREMATORY: Restlawn

24d. LOCATION (City, town, or county) (State): Coeur D'alene Ida

DATE REC'D BY LOCAL REG.: Sept 14-67

REGISTRAR'S SIGNATURE: Dale Cornell

25. EMBALMER: Derrell J. Juelfs

LICENSE NO.: E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4160
Local Reg. No. 59
Reg. Dist. No. 140

BIRTH NO.

RECEIVED OCT 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Vallard Addition
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rural Wallace

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 405 b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location) Vallard Addition

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Peter		De Block	Sept. 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married 3	June 12, 1883	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04	Farming	Belgium	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-54-0657	Mathilde De Block	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
9-14 m.		

22. *I hereby certify that I attended the deceased from* 9-14-67 *to* 9-14-67, *that I last saw the deceased alive on* 9-14-67, *and that death occurred at* 5:40 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. M. Peterson M.D.	Wallace, Idaho	9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	9-16-67	Smith & Co.	Spokane, Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept 20-67	Dan Harsell	Dale L. Cornell	E 406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4161
Local Reg. No.
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Enroute to Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 401
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. STREET ADDRESS (If rural, give location): 809 South Division

3. NAME OF DECEASED (Type or Print)
a. (First): HARRY
b. (Middle): L.
c. (Last): BEX

4. DATE OF DEATH (Month) (Day) (Year): Sept. 21, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 18, 1899
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Miner 07
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nick Bex — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-10-2175
17. INFORMANT'S OWN SIGNATURE: Rachel A. Galloway — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-21, 1967 *to* 9-21, 1967, *that I last saw the deceased alive on* 9-21, 1967, *and that death occurred at* 2:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: A. M. Peterson, M.D. 414 (Degree or title)
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 9-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 10-3-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Donald Maisel
LICENSE NO.: 452

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: MAISEL'S FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4162
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

RECEIVED OCT 6 1967 505 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn
LENGTH OF STAY (in this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION Home at 1256 Garden Ave. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn
d. STREET ADDRESS (If rural, give location) 1256 Garden Ave.

3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) c. (Last) GREBIL

4. DATE OF DEATH (Month) (Day) (Year) Sept. 22, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 8, 1896
9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Miner 07
10b. KIND OF BUSINESS OR INDUSTRY Mining
11. BIRTHPLACE (State or foreign country) Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown BIRTHPLACE Pennsylvania
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. I 3
16. SOCIAL SECURITY NO. 518-01-8775
17. INFORMANT'S OWN SIGNATURE Mrs Ora E. Grebil ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Carcinoma of Lung & Metastases — INTERVAL BETWEEN ONSET AND DEATH few months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fibrosis of Chest-Bilateral & Emphysema — Many years
DUE TO (c) arteriosclerotic Heart Disease — Several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Injured Cervical Spine & Partial Paralysis of Left Upper Extremity — 19 years
Osteoarthritis of Spine — Several years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1 1950 *to* Sept 22, 1967, *that I last saw the deceased alive on* Sept 22, 1967, *and that death occurred at* 3:10 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE J. M. Peterson (Degree or title) M.D.
23b. ADDRESS Wallace Idaho
23c. DATE SIGNED 9-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 27, 1967
24c. NAME OF CEMETERY OR CREMATORY Mullan
24d. LOCATION (City, town, or county) (State) Mullan, Idaho

DATE REC'D BY LOCAL REG. 10-3-67
REGISTRAR'S SIGNATURE Joe Delorme
25. EMBALMER Donald J. Maisel
LICENSE NO. E452
FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: OCT 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4163
Local Reg. No.
Reg. Dist. No.

RECEIVED OCT 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 141 West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
d. STREET ADDRESS (If rural, give location) Pinehurst, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) MAE
b. (Middle)
c. (Last) PENLAND

4. DATE OF DEATH (Month) (Day) (Year) Sept. 23, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 19, 1898
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Young — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Anna Smith — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-09-7337B
17. INFORMANT'S OWN SIGNATURE Vance Penland — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 12 1/2 hrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arterio Sclerotic Main Disease — 2 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Post op Ileus Fallowing Hysterectomy — 12 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Kellogg (COUNTY) Shoshone (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 2, 1946 *to* 23 Sept 1967 *that I last saw the deceased alive on* 22 Sept, 1967, *and that death occurred at* 3:45 m., *from the causes and on the date stated above.*

23a. SIGNATURE Glen M. Whitehead 539 (Degree or title) MD
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED 28 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg, Idaho (State)

DATE REC'D BY LOCAL REG. 10-3-67
REGISTRAR'S SIGNATURE Joe [illegible]
25. EMBALMER Robert G. Ross — LICENSE NO. E-497

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: MAISEL FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4164
Local Reg. No.
Reg. Dist. No.

RECEIVED OCT 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Wallace
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinehurst
d. STREET ADDRESS (If rural, give location): Pinehurst, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) JOHN; b. (Middle) ELDEN; c. (Last) HERTZIG

4. DATE OF DEATH: (Month) (Day) (Year) Sept. 23, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 17, 1910
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Zinc Plant Man
10b. KIND OF BUSINESS OR INDUSTRY: 07 Mining
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Hertzig — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Anna Braunig — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-12-6233
17. INFORMANT'S OWN SIGNATURE: Bertha May Hertzig — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

420

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1966, 19___, *to* 23 Sept, 1967, *that I last saw the deceased alive on* 22 Sept, 1967, *and that death occurred at* 5:22 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert J Russell — 435 (Degree or title): MD
23b. ADDRESS: Wallace Idaho
23c. DATE SIGNED: 27 Sept 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: 10-3-67
REGISTRAR'S SIGNATURE: Joe Devine
25. EMBALMER: Donald Maisel — LICENSE NO.: E452
FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

OCT 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 9 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 3 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4165
Local Reg. No. 4
Reg. Dist. No. 620

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Teton 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Driggs
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): County Road Near Bates 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Teton 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
d. STREET ADDRESS (If rural, give location): R.F.D. Bates, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DAVID	KEITH	BOWEN	Sept. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married /	20 July 1948	19				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: -------
11. BIRTHPLACE (State or foreign country): Driggs, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lowell D. Bowen — BIRTHPLACE: Driggs, Idaho
14. MOTHER'S MAIDEN NAME: Mary Jeanette James — BIRTHPLACE: Rexburg, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 518-56-3221
17. INFORMANT'S OWN SIGNATURE: X Lowell D. Bowen — ADDRESS: Driggs Idah

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage From Superior Aorta — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Multiple injuries From Auto accident

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

Aorta and Vena Cava - severed

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	County Road	Driggs (Bates) 13	Teton 410	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Sept 10, 67 9 a.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Car accident

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 9:00A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. F. Green 583	Coroner 4	Driggs, Idaho	9-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	13 Sept. 1967	Bates Cemetery	Bates, Teton Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-27-67	Ella Driggs	Robert C. Bean	E456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4166
Local Reg. No. 6
Reg. Dist. No. 620

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Teton 410 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Driggs
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 410 b. COUNTY Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Driggs
d. STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED (Type or Print) a. (First) DANIEL b. (Middle) SCOTT c. (Last) SORENSEN

4. DATE OF DEATH (Month) (Day) (Year) Sept. 11, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH 2 March 1897

9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY Farming-Ranching

11. BIRTHPLACE (State or foreign country) Marion, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter Sorensen BIRTHPLACE Nordrup, Denmark

14. MOTHER'S MAIDEN NAME Mary Elizabeth Lewis BIRTHPLACE Marion, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) ------

16. SOCIAL SECURITY NO. 519-05-6457

17. INFORMANT'S OWN SIGNATURE x Laura M. Dagsen ADDRESS Tacoma Washington

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Uremia INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastatic Ca of prostate 22 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1962, *to* death, 19--, *that I last saw the deceased alive on* Sept 11, 1967, *and that death occurred at* 12:20P m., *from the causes and on the date stated above.*

23a. SIGNATURE K Headrup, MD (Degree or title)

23b. ADDRESS Driggs, Idaho

23c. DATE SIGNED 9-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 14 Sept. 67

24c. NAME OF CEMETERY OR CREMATORY Driggs Cemetery

24d. LOCATION (City, town, or county) (State) Driggs, Teton Co., Idaho

DATE REC'D BY LOCAL REG. 9-27-67

REGISTRAR'S SIGNATURE Ella Driggs

25. EMBALMER Robert V. Bean LICENSE NO. E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES; Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4167
Local Reg. No. 6
Reg. Dist. No. 620

RECEIVED OCT 4 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Teton 410 — 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ~~Victor~~ Driggs
c. LENGTH OF STAY (in this place): 20 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 410
b. COUNTY: Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Victor
d. STREET ADDRESS (If rural, give location): rural - 1½ mi east of Victor, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle):
c. (Last): VANN

4. DATE OF DEATH (Month) (Day) (Year): Sept. 22, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Dec 11, 1897
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired 29
10b. KIND OF BUSINESS OR INDUSTRY: x x x x x
11. BIRTHPLACE (State or foreign country): Johannasburg, South Africa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Vann — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Catherine Christine Glas — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 553-30-1011
17. INFORMANT'S OWN SIGNATURE: Leanne Vann — ADDRESS: Victor, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): P. Neumonia Lobar — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Bronchogenic Ca — 1 year
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1961, *to* 9-22, 1967, *that I last saw the deceased alive on* 9-22, 1967, *and that death occurred at* 2:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): V Head MD 219
23b. ADDRESS: Driggs, Idaho
23c. DATE SIGNED: 9-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Victor Cemetery
24d. LOCATION (City, town, or county) (State): Victor, Teton Co., Idaho

DATE REC'D BY LOCAL REG.: 10-2-67
REGISTRAR'S SIGNATURE: Ella Griggs
25. EMBALMER: Robert Bean
LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robert Bean Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4168
Local Reg. No. 10-318
Reg. Dist. No. 460

Certificate of Death

RECEIVED
SEP 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 420 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 20 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
d. STREET ADDRESS (If rural, give location) 416 6th St.

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) F.
c. (Last) Theener

4. DATE OF DEATH (Month) (Day) (Year) September 3, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH December 22, 1887
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Breeze, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Fredrick Theener — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Caroline Ditmer — BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-54-1891-JI
17. INFORMANT'S OWN SIGNATURE J. A. Theener — ADDRESS Filer, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral accident — INTERVAL BETWEEN ONSET AND DEATH: weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Generalized arteriosclerosis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Arteriosclerotic heart dis — Years

331X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 10, 1965, *to* Sept 3, 1967, *that I last saw the deceased alive on* Sept 3, 1967, *and that death occurred at* 5:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 118 (Degree or title)
23b. ADDRESS 122 9th Ave No Buhl.
23c. DATE SIGNED 9-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 9-12-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER [signature]
LICENSE NO. E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

SEP 26 1967

JAN 06 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO.

RECEIVED SEP 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4169
Local Reg. No. 2377
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 (000)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Twin Falls Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Twin Falls
d. STREET ADDRESS (If rural, give location): R.R. #3 83301

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	M.	BEGLAN	September 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	September 7, 1905	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Service Sta. Operator	86	Eureka, California	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mathias Beglan	California	Margaret E. Crooker	California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-07-8397	James M. Beglan	Twin Falls Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	BRAIN TUMOR (ASTROCYTOMA GRADE III)	1yr.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	DIABETES MELLITUS - ADULT TYPE	1yr

1930

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Dec 1966	SAME AS ABOVE	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-28-66, 19__, *to* 9/4/, 1967, *that I last saw the deceased alive on* 9-4-67, 19__, *and that death occurred at* 9:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Joseph W. Marshall 330 (Degree or title) M.D.	Twin Falls, Idaho	9-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/7/67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
9-8-67	Pamela J. Johnson	Paul U. Reynolds	Twin Falls, Idaho

Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DPH-48021

SEP 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 31 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of Paul O. Reynolds Lic. No. E-495 at Twin Falls on 8-4-67

ADDITIONAL REMARKS by Physician

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED
SEP 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4170
Local Reg. No. D-319
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 420 Twin Falls 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl 83316
c. TIME (in this place): 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Castleford 83321
d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print)
a. (First): SARAH
b. (Middle): E.
c. (Last): HUDSON

4. DATE OF DEATH (Month) (Day) (Year): Sept. 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 25, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Marble, Arkansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Spencer — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Paralee Gage — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-28-6001
17. INFORMANT'S OWN SIGNATURE: Earl Hudson — ADDRESS: Rt #2 Buhl 83316

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypertensive heart disease — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Hypertension — Years
DUE TO (c): Arteriosclerosis — "

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 21, 1961, *to* Sept. 7, 1967, *that I last saw the deceased alive on* Sept 6, 1967, *and that death occurred at* 3:30 a. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 118
23b. ADDRESS: Buhl Idaho 83316
23c. DATE SIGNED: 9-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/9/67
24c. NAME OF CEMETERY OR CREMATORY: Buhl
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 9-13-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: George Farmer
LICENSE NO.: E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

SEP 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
SEP 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4171
Local Reg. No. D-32
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) ONE YEAR
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home: 255 Blue Lakes 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) "255 Blue Lakes

3. NAME OF DECEASED (Type or Print)
a. (First) E.
b. (Middle) H.
c. (Last) BEAN

4. DATE OF DEATH (Month) (Day) (Year) Sept. 7, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Feb. 20, 1898

9. AGE (In years last birthday) 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired FishFarmer

10b. KIND OF BUSINESS OR INDUSTRY Fish Farm

11. BIRTHPLACE (State or foreign country) Dora, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Edward F. Bean
BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Ellen Ewing
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 519-22-3027a

17. INFORMANT'S OWN SIGNATURE Mrs. E. H. Bean
ADDRESS Twin Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 24 hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Lungs with — 15 mon.
DUE TO (c) Metastases.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

163X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/18, 1967, *to* 9/7, 1967, *that I last saw the deceased alive on* 9/6, 1967, *and that death occurred at* 8:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Roy O. Shaub (Degree or title) M.D. 466

23b. ADDRESS 676 Shoup Ave W. Twin Falls Ida

23c. DATE SIGNED 9/8/67.

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Sept. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls Idaho

DATE REC'D BY LOCAL REG. 9-20-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER [signature]
LICENSE NO. E-343
FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

12

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4172
Local Reg. No. D-315
Reg. Dist. No. 460

BIRTH NO.

SEP 1 1 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 2 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240
b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerman
d. STREET ADDRESS (If rural, give location) Rural Route 1

3. NAME OF DECEASED (Type or Print)
a. (First) Effie
b. (Middle) Mae
c. (Last) Thayer

4. DATE OF DEATH (Month) Sept. (Day) 8, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH March 26, 1877
9. AGE (In years last birthday) 90 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookeeper 19
10b. KIND OF BUSINESS OR INDUSTRY County Clerk Office
11. BIRTHPLACE (State or foreign country) Kings Valley, Oregon
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Crosno — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Charlotte Ellen King — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-60-8495
17. INFORMANT'S OWN SIGNATURE Joan Carter — ADDRESS 320 Main Buhl, Idah

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart dis — Years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/30/65, 19__, *to* 9/7/67, 19__, *that I last saw the deceased alive on* 9/7/67, 19__, *and that death occurred at* 3:40a *m., from the causes and on the date stated above.*

23a. SIGNATURE C. A. Cullings 118 (Degree or title) MD
23b. ADDRESS Buhl Id
23c. DATE SIGNED 9-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sept. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY Toledo Cemetery
24d. LOCATION (City, town, or county) (State) Toledo, Oregon

DATE REC'D BY LOCAL REG. 9-8-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Jim A. Hopkins
LICENSE NO. E-482

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buhl Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4173
Local Reg. No. 10-321
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
SEP 21 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sky View Manor 223

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 640 Filer Avenue West

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): H.
c. (Last): MILLS

4. DATE OF DEATH (Month) (Day) (Year): September 9,1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 4,1877
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret.Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Withville,Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Mills — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Rebecca — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-01-8190
17. INFORMANT'S OWN SIGNATURE: Twin Falls, Idaho — ADDRESS: x Gladys E. Barnett

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive heart failure
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Old age
DUE TO (c): Gen Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1966 *to* 9/91, 1967, *that I last saw the deceased alive on* 9 9, 1967, *and that death occurred at* 8:55a. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 146 M.D.
23b. ADDRESS: Twin Falls,Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/13/67
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls,Idaho

DATE REC'D BY LOCAL REG.: 9-18-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. FUNERAL DIRECTOR ADDRESS: Reynolds Funeral Chapel-Twin Falls,Idaho
James C. Reynolds
P.O. Box 1142 733-4900

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of James C. Reynolds Lic. No. E-279 at Twin Falls on 9/9/67

ADDITIONAL REMARKS by Physician

Certificate of Death

STATE OF IDAHO

State File No. 4174
Local Reg. No. D-320
Reg. Dist. No. 460

RECEIVED
SEP 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 83316
d. STREET ADDRESS (If rural, give location) 623 North Broadway

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LILLIAN	A.	HYDE	Sept. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Sept. 11, 1890	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Mt. Vernon, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Albert Ellis	Unknown	Minnie Davis	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-28-0452D	Gerald O. Hyde	2939 Logan Way Salt Lake City, Utah 84108

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4288 Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart dis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — year

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 26, 1967 *to* Sept. 10, 1967, *that I last saw the deceased alive on* Sept 10, 1967, *and that death occurred at* 10:20 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Buhl Idaho 83316	9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/13/67	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-13-67	Pamela J. Johnson	George Tanner	E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 23 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 14 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4175
Local Reg. No. 325
Reg. Dist. No. 460

RECEIVED SEP 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 427
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hansen 83334
d. STREET ADDRESS (If rural, give location): 118 Poplar

3. NAME OF DECEASED (Type or Print)
a. (First): HOWARD
b. (Middle): C.
c. (Last): WALTON

4. DATE OF DEATH (Month) (Day) (Year): September 11, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: December 29, 1924
9. AGE (In years last birthday): 42 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane Operator- 11
10b. KIND OF BUSINESS OR INDUSTRY: Sugar Factory
11. BIRTHPLACE (State or foreign country): Tin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S

13. FATHER'S NAME: S.A. Walton
BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-24-4022
17. INFORMANT'S OWN SIGNATURE: Mrs Howard C. Walton ADDRESS: Hansen

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebrovascular Thrombosis — 2 weeks
DUE TO (c) Diabetes Mellitus — 25 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1951, *to* Sept. 11, 1967, *that I last saw the deceased alive on* Sept. 11, 1967, *and that death occurred at* 7:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O. Ellis Knight MD 284
23b. ADDRESS: TWIN FALLS, IDAHO
23c. DATE SIGNED: 9.12.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9.14.67
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 9-20-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: Wayne Walton
LICENSE NO.: 343
FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 17 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4176
Local Reg. No. D-324
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH NO.

SEP 21 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 83316
d. STREET ADDRESS (If rural, give location) 229 8th Avenue North

3. NAME OF DECEASED (Type or Print)
a. (First) EDWARD
b. (Middle) ELLIS 144
c. (Last) WOODRUFF

4. DATE OF DEATH (Month) (Day) (Year) Sept. 11, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 3, 1893
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY Life Insurance
11. BIRTHPLACE (State or foreign country) Seymore County, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward aWoodruff — BIRTHPLACE No Record
14. MOTHER'S MAIDEN NAME No Record — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW I 3
16. SOCIAL SECURITY NO. 518-07-8589
17. INFORMANT'S OWN SIGNATURE Mrs Gertrude Woodruff — ADDRESS 229 8th N. Buhl, Idaho 83316

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5271

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart failure c̄ Cardiomegaly — INTERVAL BETWEEN ONSET AND DEATH: 20 Days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) and Cardiac Asthma
DUE TO (c) Marked Pulmonary Emphysema — 2 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* & Dependent Edema — 20 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1948, *to* 9-11, 1967, *that I last saw the deceased alive on* 9-11-, 1967, *and that death occurred at* 8:20 Am., *from the causes and on the date stated above.*

23a. SIGNATURE D. A. McCluskey MD 336 (Degree or title)
23b. ADDRESS Twin Falls Idaho 83301
23c. DATE SIGNED 9-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/13/67
24c. NAME OF CEMETERY OR CREMATORY Buhl
24d. LOCATION (City, town, or county) (State) Buhl, 83316 Idaho

DATE REC'D BY LOCAL REG. 9-19-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER George Farmer
LICENSE NO. E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 3 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4177
Local Reg. No. D-329
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 21 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (In this place) D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls 83301
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural, Route # 2
d. STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print)
a. (First) ALBERTENA
b. (Middle) C.
c. (Last) NELSON

4. DATE OF DEATH (Month) (Day) (Year) September 11, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: November 6, 1891
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Beecher, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Boehm — BIRTHPLACE: United States
14. MOTHER'S MAIDEN NAME: Katherine Weis — BIRTHPLACE: United States

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 518-44-24240
17. INFORMANT'S OWN SIGNATURE: C J Nelson — ADDRESS: Twin Falls, Ida. 83301

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	MYOCARDIAL INFARCTION	1½ Years
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	CORONARY ARTERY DISEASE	?
DUE TO (c)	GENERALIZED ARTERIOSCLEROSIS	?
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	DIABETES MELLITUS, OBESITY	3 years
	HYPERTENSION.	25 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-11, 1963 *to* 9-11-, 1967, *that I last saw the deceased alive on* 8-28-, 1967, *and that death occurred at* 11:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: George E. Brown, MD. 061 (Degree or title) 1
23b. ADDRESS: TWIN FALLS, IDAHO 83301
23c. DATE SIGNED: 9-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Sept. 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 9-20-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: [signature]
LICENSE NO. E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600 83301

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 30 1974

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 4 1974

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

DEC 5 1974

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4178
Local Reg. No. D-329
Reg. Dist. No. 460

RECEIVED SEP 21 1967 Bureau of

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (in this place) 1 YR.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 1219 10th Ave East

3. NAME OF DECEASED (Type or Print)
a. (First) Besse
b. (Middle) J.
c. (Last) Detwiler

4. DATE OF DEATH (Month) (Day) (Year) September 12, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH September 27, 1882
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME
11. BIRTHPLACE (State or foreign country) Cedarville, Kansas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John Johnston — BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Frances Dollarhide — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 519 05 9131 A
17. INFORMANT'S OWN SIGNATURE X Blanche Hodge — ADDRESS Twin Falls 220-8th Ave. No.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cardio-Vascular Disease c̄ myocardial failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardio-Vascular Disease
DUE TO (c) Diabetes Millitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 7, 1950, *to* Sept 12, 1967, *that I last saw the deceased alive on* Aug 15, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE E Elwood A Rees 431 (Degree or title) MD
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 9-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9.14.67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 9-20-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER [signature]
LICENSE NO. E-343

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: White Mortuary Twin Falls, Idaho
733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4179
Local Reg. No. D-322
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED SEP 21 1967 000

1. PLACE OF DEATH
a. COUNTY: 42 / Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 340
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Paul 83347
d. STREET ADDRESS (If rural, give location): R.R.#2 Box 159

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle): ARMSTEAD
c. (Last): HOUSE

4. DATE OF DEATH (Month) (Day) (Year): September 14, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: May 24, 1966
9. AGE (In years last birthday): 1 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Burley, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Eugene B. House — BIRTHPLACE: Sterling, Colorado
14. MOTHER'S MAIDEN NAME: Dorothy Black — BIRTHPLACE: Wendell, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Eugene Barney House — ADDRESS: Paul, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

490X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Chronic congestive failure
DUE TO (c): Atrioventricularis communis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Mongolism (Down's syndrome

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/8, 1966, *to* 9/14/, 1967, *that I last saw the deceased alive on* 9/14, 1967, *and that death occurred at* 2:05a. *m., from the causes and on the date stated above.*

23a. SIGNATURE: T. M. Myers, R.D. 576 (Degree or title): 1 M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 9/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/16/67
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 9-18-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. FUNERAL DIRECTOR: James E. Reynolds — Reynolds Funeral Chapel — ADDRESS: Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of James C. Reynolds Lic. No. E-279 at Twin Falls on 9/14/67

ADDITIONAL REMARKS by Physician

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 25 1967 Bureau of Vital Statistics

State File No. 4180
Local Reg. No. D-334
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hansen
d. STREET ADDRESS (If rural, give location) Box 64

3. NAME OF DECEASED (Type or Print) a. (First) FRANK b. (Middle) CHARLES c. (Last) WRIGHT

4. DATE OF DEATH (Month) (Day) (Year) September 15, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 31, 1902

9. AGE (In years last birthday) 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Berryville, Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Bert E. Wright
BIRTHPLACE Berryville, Ark.

14. MOTHER'S MAIDEN NAME unknown
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-09-6756

17. INFORMANT'S OWN SIGNATURE & Leah Wright ADDRESS Hansen, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cirrhosis Portal — 5 years
DUE TO (c) Rheumatic Heart Disease — 50 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1955, *to* 9/15/, 1967, *that I last saw the deceased alive on* Sept. 15, 1967, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Willis Knight MD 286 (Degree or title) M.D.

23b. ADDRESS Kimberly, Idaho

23c. DATE SIGNED 8-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/18/67

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 9-21-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. FUNERAL DIRECTOR Reynolds Funeral Chapel ADDRESS Twin Falls, Idaho

James E. Reynolds

Federal Security Agency
United States Public Health Service

Form DPH-[illegible]

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of James C.Reynolds Lic. No. E-270 at Twin Falls on 9/15/67

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4181
Local Reg. No. D-333
Reg. Dist. No. 460

RECEIVED
Bureau of Vital Statistics
SEP 25 1967

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY IN (this place) 12 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 421 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 640 Filer Avenue West

3. NAME OF DECEASED (Type or Print)
a. (First) LAVINNA
b. (Middle)
c. (Last) CHILDS

4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Oct. 11, 1880

9. AGE (In years last birthday) 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY own home

11. BIRTHPLACE (State or foreign country) Oakdale, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME D. T. Chapman
BIRTHPLACE Wisconsin

14. MOTHER'S MAIDEN NAME Eliza Bundy
BIRTHPLACE New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 518-36-6412-D

17. INFORMANT'S OWN SIGNATURE Mrs. D. C. Brannen
ADDRESS Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis Causing Aneurysm Rt. Carotid and Abdominal Arteries with — 10 yrs
DUE TO (c) Semi-Paralysis entire lower extremities including bowel and bladder — 7 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. — 7 yrs.

4201

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-3, 1953, *to* 9-15, 1967, *that I last saw the deceased alive on* 9-15, 1967, *and that death occurred at* 6:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE D. A. McCluskey MD 338 (Degree or title)

23b. ADDRESS Twin Falls Idaho

23c. DATE SIGNED 9-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Sept. 19, 1967

24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery

24d. LOCATION (City, town, or county) Buhl (State) Idaho

DATE REC'D BY LOCAL REG. 9-21-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER

LICENSE NO. E-343

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service

Form DH-62021

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4182
Local Reg. No. D-330
Reg. Dist. No. 460

RECEIVED SEP 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 47
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 17 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence--RFD # 3 83316

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl 83316
d. STREET ADDRESS (If rural, give location) R.F.D. # 3

3. NAME OF DECEASED (Type or Print)
a. (First) REUBEN
b. (Middle) FRANK
c. (Last) BRITTAIN

4. DATE OF DEATH (Month) (Day) (Year) Sept. 15, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH May 12, 1893

9. AGE (In years last birthday) 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Guthrie, Oklahoma

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Fred Brittain
BIRTHPLACE No Record

14. MOTHER'S MAIDEN NAME Mary Rooks
BIRTHPLACE No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-05-4372A

17. INFORMANT'S OWN SIGNATURE Mrs R.F. Brittain RFD # 3, Buhl, Idaho 83316
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH: Months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 10, 1967, *to* Sept 15, 1967, *that I last saw the deceased alive on* Sept. 14, 1967, *and that death occurred at* about 4:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)

23b. ADDRESS 122 9th Ave. N. Buhl, Idaho 83316

23c. DATE SIGNED 9/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/18/67

24c. NAME OF CEMETERY OR CREMATORY Buhl

24d. LOCATION (City, town, or county) Buhl, (State) Idaho

DATE REC'D BY LOCAL REG. 9-21-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Robert T. Dickard

LICENSE NO. E-312

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-630 21

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4183
Local Reg. No. 10-331
Reg. Dist. No. 460

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazeldel Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 1307 6th Ave. East

3. NAME OF DECEASED (Type or Print): a. (First) DONALD b. (Middle) c. (Last) SMOCK

4. DATE OF DEATH (Month) (Day) (Year): September 16, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: August 11, 1911

9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24

10b. KIND OF BUSINESS OR INDUSTRY: Electric Supply

11. BIRTHPLACE (State or foreign country): Twin Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harry Smock
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Alice May Thompson
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 528-16-7627-HA

17. INFORMANT'S OWN SIGNATURE: Harry E Smock
ADDRESS: Twin Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Insulin reaction, severe — 2 hrs.
DUE TO (c) Acute alcoholism & diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition due to chronic relapsing pancreatitis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-2, 1956, *to* 9-16, 1967, *that I last saw the deceased alive on* 9-16, 1967, *and that death occurred at* 8:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 423 (Degree or title) M.D.

23b. ADDRESS: 1216 Filer Ave. E. Twin Falls

23c. DATE SIGNED: 9-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Sept. 19, 1967

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.: 9-21-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: [signature]

LICENSE NO.: E-343

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4184
Local Reg. No. D-328
Reg. Dist. No. 460

BIRTH NO.

RECEIVED SEP 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) Elwin Motel # 6

3. NAME OF DECEASED (Type or Print) a. (First) WALTER b. (Middle) E. c. (Last) HANLON
4. DATE OF DEATH (Month) (Day) (Year) September 17, 1967
5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) separated
8. DATE OF BIRTH August 15, 1884
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) store operator 22
10b. KIND OF BUSINESS OR INDUSTRY Used retail
11. BIRTHPLACE (State or foreign country) Yuma, Colorado
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME David Hanlon BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME unknown BIRTHPLACE unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO. 518-70-8485A
17. INFORMANT'S OWN SIGNATURE ADDRESS Donald Hanlon Las Vegas, Nev.

4201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease, unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Acute Urinary Retention

19a. DATE OF OPERATION 9/15/67
19b. MAJOR FINDINGS OF OPERATION Benign Prostatic Hypertrophy
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/5, 1967, *to* 9/15, 1967, *that I last saw the deceased alive on* 9/15, 1967 *and that death occurred at* 5:20 m., *from the causes and on the date stated above.*

23a. SIGNATURE George T. Davis (Degree or title) MD
23b. ADDRESS Twin Falls 2d
23c. DATE SIGNED 9/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Sept. 19, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. 9-20-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER
LICENSE NO. E-343
FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4185
Local Reg. No. D-336
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42/ Twin Falls 201
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY IN THIS PLACE 49 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sky View Manor 223

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42/
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 535 Bolton

3. NAME OF DECEASED (Type or Print): a. (First) LEVEN b. (Middle) MADISON c. (Last) KEPLINGER

4. DATE OF DEATH (Month) (Day) (Year): Sept. 17, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced 4

8. DATE OF BIRTH: Feb. 17, 1876

9. AGE (In years last birthday): 91
If UNDER 1 YEAR: Months | Days
If UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: general labor

11. BIRTHPLACE (State or foreign country): Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin Keplinger
BIRTHPLACE: Tenn.

14. MOTHER'S MAIDEN NAME: Sara Emma Sharp
BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service) - - - -

16. SOCIAL SECURITY NO.: unkn

17. INFORMANT'S OWN SIGNATURE: x Mrs. J. K. Egbert
ADDRESS: Murtaugh Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary arteriosclerosis — 5 yrs

DUE TO (c) Gen. Arteriosclerosis — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Peptic ulcer — 3 months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) - - - -

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - - - - - - -

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) - - - - - - - - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* 2-3-61, 19__, *to* 9-17-67, 19__, *that I last saw the deceased alive on* 9-17-67, 19__, *and that death occurred at* 8:00a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Willard H. Couch M.D. (Degree or Title)

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 9-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 9-20-1967

24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 9-22-67

REGISTRAR'S SIGNATURE: Vera Ryals

25. EMBALMER: Dale A. Patterson
LICENSE NO.: E-451
FIRM NAME: TWIN FALLS MORTUARY.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4186
Local Reg. No. D-332
Reg. Dist. No. 460

RECEIVED
SEP 25 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hosp. 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Hazelton 83355
d. STREET ADDRESS (If rural, give location) Hazelton

3. NAME OF DECEASED (Type or Print)
a. (First) GRAYCE
b. (Middle) BAIRD
c. (Last) HELLER

4. DATE OF DEATH (Month) (Day) (Year) Sept. 18, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH August 10,1923
9. AGE (In years last birthday) 44 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Hazelton, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Winfield S. Baird — BIRTHPLACE Kentucky
14. MOTHER'S MAIDEN NAME Myrtle G. Atherton — BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ---
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs Ralph Baird — ADDRESS Hazelton, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis c̄ Convulsive Seizures — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Peripheral Neuropathy + Muscular Dystrophy — 1½ yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Aplastic Anemia and Hypoalbuminemia — 6 months

368X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-4, 1967, *to* 9-18, 1967, *that I last saw the deceased alive on* 9-18, 1967, *and that death occurred at* 10:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE D. A. McQuesky MD 338 (Degree or title) 1
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 9-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Sept. 20,1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. 9-21-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. SEP 12 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. FEB 16 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4187
Local Reg. No. D-335
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

SEP 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 215 Polk 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 215 Polk

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) P.
c. (Last) BINDER

4. DATE OF DEATH (Month) (Day) (Year) September 20, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH February 13, 1868
9. AGE (In years last birthday) 99 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Muskatine, Iowa
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John Geo. Binder — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Catherine Bald — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-18-0155A
17. INFORMANT'S OWN SIGNATURE + Mary J Binder — ADDRESS Twin Falls, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 12, 1967, *to* Sept. 20, 1967, *that I last saw the deceased alive on* 9-15, 1967, *and that death occurred at* 1:30 Am., *from the causes and on the date stated above.*

23a. SIGNATURE Dean H. Abblech MD 003 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 9.20.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9.23.67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 9-22-67
REGISTRAR'S SIGNATURE Vera Ryals
25. EMBALMER [signature]
LICENSE NO. 343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendent. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Amended Nov. 8, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4188
Local Reg. No. D-337
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42/ Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HazelDelle Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42/ b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 640 Filer Ave. W.

3. NAME OF DECEASED (Type or Print) a. (First) W. b. (Middle) Ray c. (Last) Lee

4. DATE OF DEATH (Month) (Day) (Year) Sept. 22, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married /

8. DATE OF BIRTH August 14, 1894

9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist 21/

10b. KIND OF BUSINESS OR INDUSTRY Drugs

11. BIRTHPLACE (State or foreign country) St. Joseph, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William H. Lee
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Lessie Bigham
BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes
(If yes, give war or dates of service) WW #1 2

16. SOCIAL SECURITY NO. 541-36-2754

17. INFORMANT'S OWN SIGNATURE Orie E. Lee
ADDRESS Portland, Oregon

18. CAUSE OF DEATH 446X
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Nephrosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease — Years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒X

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* pronounced only, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 11 p *m., from the causes and on the date stated above.*

23a. SIGNATURE H. Thad Scholes, M.D. 707 (Degree or title)

23b. ADDRESS 120 Adams, Twin Falls, Idaho

23c. DATE SIGNED 9-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE Sept 24, 1967

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) Hood River, Oregon

DATE REC'D BY LOCAL REG. 9-25-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Hugh Phillips

LICENSE NO. E-343

FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED NOV 6 1967 Bureau of Vital Statistics

State of Idaho } ss.
County of Twin Falls }

Certificate No. 67-4188

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for W. Ray Lee (Name on Original Certificate) who died (Was Born or Died) on Sept 22, 1967 (Date of Event)
in Twin Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	August 14, 1895	August 14, 1894
Age	72	Age 73

Subscribed and sworn to before me this 2 day of Nov, 19 67

Notary Public, residing at Twin Falls Ida

My commission expires April 13-1970

(Seal)

Signed (Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

136 4th Ave. East Twin Falls, Ida.
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of } ss.
County of }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 2 day of Nov, 19 67

Notary Public residing at Twin Falls Ida

My commission expires April 13-1970

(Seal)

Signed (Signature of Any Credible Person)

259 Taylor Twin Falls, Idaho
(Street Address, City, State)

FORM PH 60-155

10-31-67 AP

NOTARY
PUBLIC
STATE OF IDAHO

NOTARY
PUBLIC
STATE OF IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4188
Local Reg. No. 0-339
Reg. Dist. No. 460

BIRTH NO.

RECEIVED SEP 27 1967 VITAL STATISTICS

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. Length of STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazelwood Manor

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 640 Filer Av. W.

3. NAME OF DECEASED (Type or Print): a. (First) W. RAY b. (Middle) c. (Last) LEE

4. DATE OF DEATH (Month) (Day) (Year): Sept. 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	August 14, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pharmacist	Drugs	St. Joseph, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William H. Lee	Unknown	Lessie Bigham	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW#1	541-36-2754	Ora E. Lee	Portland, Oregon

4467

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Nephrosclerosis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Pronounced Only 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 11 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. Thad Scholes M.D.	120 Adams Twin Falls, Ida	9-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Sept. 24, 1967		Hood River, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-25-67	Pamela J. Johnson		E-343

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 9 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 30 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4189
Local Reg. No. D-338
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED SEP 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 83301 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley MemorialHosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011
b. COUNTY Ada Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 83705
d. STREET ADDRESS (If rural, give location) 1014 South Orchard

3. NAME OF DECEASED (Type or Print)
a. (First) Arthur
b. (Middle) F. 143
c. (Last) Botsford

4. DATE OF DEATH (Month) (Day) (Year) Sept. 24, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 24, 1896
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
10b. KIND OF BUSINESS OR INDUSTRY DeptPublic Idaho State Employee
11. BIRTHPLACE (State or foreign country) Arcadia, Nebraska
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME FrankEdgar Botsford 08 BIRTHPLACE WestUnion, Iowa
14. MOTHER'S MAIDEN NAME Letitia Jane Elliott BIRTHPLACE Yonkers, N.Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW 1 (If yes, give war or dates of service) US Army 3
16. SOCIAL SECURITY NO. 463-26-1144
17. INFORMANT'S OWN SIGNATURE Catharine L. Botsford ADDRESS Boise, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 4 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — unknown
DUE TO (c) — unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Prostate

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/24, 1967, *to* 9/24, 1967, *that I last saw the deceased alive on* 9/24, 1967, *and that death occurred at* 1:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE C. F. Winster MD. 578 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 9.25.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9.27.67
24c. NAME OF CEMETERY OR CREMATORY Cloverdale
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 9-25-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. 343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WhiteMortuary Twin Falls, Idah

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 1 1 1987

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4190
Local Reg. No. D-340
Reg. Dist. No. 460

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 42 307
b. CITY OR TOWN: Twin Falls
LENGTH OF STAY (in this place): one week
d. FULL NAME OF HOSPITAL OR INSTITUTION: Magic Valley Mem Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN: Rupert
d. STREET ADDRESS (If rural, give location): 633 5th street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Una	M	Bartlett	Sept 24 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	July 6th 1898	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Beautician 05		Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unknown Fortner	unknown	unknown Fifield	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-36-8853	[signature]	Rupert Idah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardiovascular Disease — hours
DUE TO (c) — 3 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Small bowel obstruction

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Sept 13 67	Small bowel obstruction due to adhesions	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-12, 1967, *to* 9-24, 1967, *that I last saw the deceased alive on* 9-23, 1967 *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George W. Warner	MD	111 6th Ave E Twin Falls	9/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Sept 24 1967	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-28-67	Pamela J. Johnson	Robert C Walker	E 294

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-6502

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4191
Local Reg. No. D-339
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Hansen
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) R.R.#1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Hansen 83334
d. STREET ADDRESS (If rural, give location) R.R.#1

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) GERALD
c. (Last) STANGER

4. DATE OF DEATH (Month) (Day) (Year) September 24,1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 11,1913
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) West Weaver,Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME W.B.Stanger — BIRTHPLACE West Weaver,Utah
14. MOTHER'S MAIDEN NAME Mary E.Bingham — BIRTHPLACE Trenton,Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-26-8401
17. INFORMANT'S OWN SIGNATURE Mrs. W.G. Stanger — ADDRESS Hansen, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9748

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hanging

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm home 02
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 420 (STATE) Hansen Twin Falls Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Sept.24,1967 7:00a.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Coroner's Investigation only, *19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 7:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE H. Thad Tchde M.D. 583 (Degree or title) Coroner 4
23b. ADDRESS Twin Falls,Idaho
23c. DATE SIGNED 9/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 9/27/67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls,Idaho

DATE REC'D BY LOCAL REG. 9-26-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. FUNERAL DIRECTOR Paul F. Reynolds — Reynolds Funeral Chapel — ADDRESS Twin Falls,Idaho

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

OCT 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of Paul D.Reynolds Lic. No. E-279 at Twin Falls on 9/24/67

ADDITIONAL REMARKS by Physician

Certificate of Death

STATE OF IDAHO

State File No. 4192
Local Reg. No. D-35a
Reg. Dist. No. 460

RECEIVED
OCT 12 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 800 / 320
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LEE	JOSEPH	MOTT	Sept. 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Widowed 2	July 4, 1873	94	2	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04	Farming	Memphis, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Mott	Hennepin, Ill.	Mary Elizabeth Payne	Woodstock, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	535-20-2553	x Mildred Paulson	Dietrich

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 6 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis, generalized. — over 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — one year

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/25, 1967, *to* 9/25, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 10:05 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Max W. Laver MD	Twin Falls, Idaho	Sept 29, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9-28-1967	Shoshone Cemetery	Shoshone, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-10-67	Pamela J. Johnson	Francis M. Bergin	E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Information for Death Certificate obtained from Dr. R. D. Acker of Shoshone, Idaho -

Certificate of Death

STATE OF IDAHO

State File No. 4193
Local Reg. No. 10-341
Reg. Dist. No. 460

BIRTH NO.

RECEIVED OCT 2 1967 Bureau of Statistics

1. PLACE OF DEATH
a. COUNTY 23 Twin Falls
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hosp. 43

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240
b. COUNTY Minidoka
c. CITY OR TOWN Paul
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Priscilla
b. (Middle) Hartley
c. (Last) Young

4. DATE OF DEATH (Month) (Day) (Year) Sept. 26, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Sept. 11, 1883

9. AGE (In years last birthday) 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Bountiful, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Hartley - England

14. MOTHER'S MAIDEN NAME Sarah Cooper - England

BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-18-7671

17. INFORMANT'S OWN SIGNATURE Eleanor Johnson ADDRESS Calif. Pico-Rivera,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) UREMIA — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) SEPTIC EMBOLUS (AORTIC)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/18, 1967, *to* 9/26, 1967, *that I last saw the deceased alive on* 9/26, 1967, *and that death occurred at* 11:55 ~~am~~ *from the causes and on the date stated above.*

23a. SIGNATURE John M. McKa (Degree or title) M.D.

23b. ADDRESS 676 Shoup Avenue West, Twin Falls, Idaho 83301

23c. DATE SIGNED 9/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 9/29/67

24c. NAME OF CEMETERY OR CREMATORY Rose Hills Mem. Park Whittier, LosAngeles, Calif

24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG. 9-28-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Garth Payne

LICENSE NO. E 389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4194
Local Reg. No. 10-349
Reg. Dist. No. 460

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls 000
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Valley Nursing Home 250

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 42 Twin Falls
c. CITY OR TOWN Twin Falls
d. STREET ADDRESS (If rural, give location) 1897 Alturas Dr. 83301

3. NAME OF DECEASED (Type or Print) a. (First) HATTIE b. (Middle) c. (Last) JENKINS

4. DATE OF DEATH (Month) (Day) (Year) September 29, 1967

5. SEX Female

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH August 30, 1891

9. AGE (In years last birthday) 76 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 61

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Tom Buchanan BIRTHPLACE Ireland

14. MOTHER'S MAIDEN NAME Mary Ann Clark BIRTHPLACE Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-36-7586-D

17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Twin Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure from — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 10
~~DUE TO~~ (c) Rheumatic Heart Disease — 20

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Colon — 2 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-5, 1966, *to* 9-29, 1967, *that I last saw the deceased alive on* 9-29, 1967, *and that death occurred at* 9:02 m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 57B (Degree or title)

23b. ADDRESS 204 4th Ave. East Twin Falls, Idaho 83301

23c. DATE SIGNED 10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 2, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10/6/67

REGISTRAR'S SIGNATURE [signature]

25. EMBALMER [signature]

LICENSE NO. E-490

FIRM NAME: WHITE MORTUARY 733-6605

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4195
Local Reg. No. 0-323
Reg. Dist. No. 460

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

BIRTH NO. 101 340

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Twin Falls
LENGTH OF STAY (in this place) days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hospital 1144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eden 83325
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First) ALVA b. (Middle) E. c. (Last) PICKETT
4. DATE OF DEATH (Month) (Day) (Year) Sept. 29, 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 24, 1902
9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ditch rider 08
10b. KIND OF BUSINESS OR INDUSTRY Canal Co.
11. BIRTHPLACE (State or foreign country) Colorado Springs, Colorado
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Charles Pickett BIRTHPLACE unk.
14. MOTHER'S MAIDEN NAME Lois unk. BIRTHPLACE unk.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----
16. SOCIAL SECURITY NO. 519-22-2974
17. INFORMANT'S OWN SIGNATURE Hazel C Pickett ADDRESS Eden, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 331X ACUTE CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH 3 DA -

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. COMPLICATING RT HEMIPLEGIA — 3DA

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-26-67, 19___, *to* 9-29-67, 19___, *that I last saw the deceased alive on* 9-29-67, 19___, *and that death occurred at* 11:52 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Joseph W. Marshall 330 (Degree or title) MD
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10/6/67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER
LICENSE NO. 343
FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4196
Local Reg. No. D-350
Reg. Dist. No. 460

RECEIVED
OCT 12 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Hansen 83334
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print)
a. (First) HAROLD
b. (Middle) BERT 143
c. (Last) TILLEY

4. DATE OF DEATH (Month) (Day) (Year) September 30, 1967

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH January 28, 1967

9. AGE (In years last birthday) 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Rolfe, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME E. W. Tilley
BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Ann Jane Hammond
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service) —•—

16. SOCIAL SECURITY NO. 518-40-9413A

17. INFORMANT'S OWN SIGNATURE X Mrs Jack Tilley
ADDRESS Twin Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — 5 yrs.
DUE TO (c) Gen. Arteriosclerosis — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Uremia, thrombo-cytopenic purpuria--bronchopneumonia — wks.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-16-60, 19__, *to* 9-30-67, 19__, *that I last saw the deceased alive on* 9-30-67, 19__, *and that death occurred at* 8:50 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 092

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 10-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 3, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls Idaho

DATE REC'D BY LOCAL REG. 10-10-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Ronald J. Hamilton

LICENSE NO. E-490

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4197
Local Reg. No. D-342
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls — OCT 9 1967 — 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY IN THIS PLACE 3 WK
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 717 North 7th

3. NAME OF DECEASED (Type or Print): a. (First) Ivy — b. (Middle) L. — c. (Last) Bean

4. DATE OF DEATH: (Month) Sept. (Day) 30, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 4, 1883

9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Fremont, Nebr.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James Wilkins — BIRTHPLACE: Colo.

14. MOTHER'S MAIDEN NAME: Catherine Methven — BIRTHPLACE: Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-01-7017B

17. INFORMANT'S OWN SIGNATURE: X Mrs Judd Adams — ADDRESS: Buhl, Idaho 83316

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left Hemiplegia from Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertensive Arterio vascular disease — several yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

4434

19a. DATE OF OPERATION — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) — **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) — **21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)**

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m. — **21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — **21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* 9-30, 1967 *that I last saw the deceased alive on* 9-26, 1967 *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wm H Anderson MD (Degree or title) — **23b. ADDRESS**: Buhl, Idaho — **23c. DATE SIGNED**: 10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: OCT. 3, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Buhl Cemetery — **24d. LOCATION** (City, town, or county) (State): Buhl Idaho

DATE REC'D BY LOCAL REG.: 10/6/67 — **REGISTRAR'S SIGNATURE**: Pamela J. Johnson — **25. EMBALMER**: Jim A Hopkins — **LICENSE NO.**: E-482

FIRM NAME: Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4198
Local Reg. No. D-355
Reg. Dist. No. 460

Certificate of Death

RECEIVED
OCT 12 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LIMITS OF STAY (in this place) 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sky View Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) Rural - Route 2

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) George
c. (Last) MARQUART

4. DATE OF DEATH (Month) (Day) (Year) Sept. 30, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Jan. 6, 1899
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cook 01
10b. KIND OF BUSINESS OR INDUSTRY Restaurant
11. BIRTHPLACE (State or foreign country) Kenton, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.Z

13. FATHER'S NAME George Marquart — BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Zarilda McFadden — BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W.W.I 3
16. SOCIAL SECURITY NO. 518-18-8709
17. INFORMANT'S OWN SIGNATURE Nursing Home Records — ADDRESS Twin Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

150X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) / Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Carcinoma of esophagus — 1 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-18-62, 19__, *to* 9-30-67, 19__, *that I last saw the deceased alive on* 9-30-67, 19__, *and that death occurred at* 11:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE W. H. Clark MD (Degree or title) 092
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 10-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Mem. Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. 10-11-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER William J. Boyd
LICENSE NO. E-490

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Twin Falls Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4199
Local Reg. No. 27
Reg. Dist. No. 310

67-9341 RECEIVED SEP 12 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
LENGTH OF STAY (in this place) 14 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 430 Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JOLEE
b. (Middle) ANN
c. (Last) KELLAR

4. DATE OF DEATH (Month) (Day) (Year) Sept. 3, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH September 2, 1967

9. AGE (In years last birthday) | If under 1 year: Months | Days | If under 24 hrs.: Hours 14 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) McCall, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Melvin Kellar
BIRTHPLACE Cambrige, Idaho

14. MOTHER'S MAIDEN NAME Theresa VonBrathorst
BIRTHPLACE Oakland, Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Melvin L Kellar
ADDRESS New Meadows, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7545

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHIAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CONGENITAL HEART DISEASE

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-2-67, 19____, *to* 9-3-67, 19____, *that I last saw the deceased alive on* 9-3-67, 19____ *and that death occurred at* 4:05 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Ronald S Nokes M.D.

23b. ADDRESS McCall, Idaho

23c. DATE SIGNED 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Sept. 4, '67

24c. NAME OF CEMETERY OR CREMATORY Meadows Valley

24d. LOCATION (City, town, or county) Meadows, (State) Idaho

DATE REC'D BY LOCAL REG. Sept-7-1967

REGISTRAR'S SIGNATURE Myrtle M Gardner

25. EMBALMER Burton C Walker
LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4200
Local Reg. No. 23
Reg. Dist. No. 310

BIRTH NO.

RECEIVED OCT 3 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Valley 430
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): McCall Bureau Township
c. LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): McCall Nursing Home 327

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 430 Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) WALTER b. (Middle) M: c. (Last) GREENUP

4. DATE OF DEATH (Month) (Day) (Year): Sept. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Never Married)	Dec. 16, 1882	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
wood cutter & trapper	04	Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Christopher Greenup	no record	Elizabeth Osborne	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-60-0597	Ira B. Beckel	Boise, Idaho

4200

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 10+ yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Generalized Arteriosclerosis — 15 yrs

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Sept 23, 1967, *that I last saw the deceased alive on* Sept 22, 1967, *and that death occurred at* 4:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
James J Stuart 500 (Degree or title) M D	McCall Idaho	9/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/24/67	Holmes Cemetery	Valley County, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Sept-27-67	Myrtle M Gardner	Burton E Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4201
Local Reg. No. 18
Reg. Dist. No. 320

RECEIVED SEP 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): ELVIE
b. (Middle): ENGLISH 153
c. (Last): TRIMBLE

4. DATE OF DEATH (Month) 9 (Day) 1 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 9/14/1895
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill worker 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Montongo, Arkansas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Charles Trimble — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Laura Jane Wilson — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Annie M. Trimble — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertension

DUE TO (c) Gen Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-31, 1967, *to* 9-1-, 1967, *that I last saw the deceased alive on* 9-1-, 1967, *and that death occurred at* 3:27A *m., from the causes and on the date stated above.*

23a. SIGNATURE: 344 [signature] (Degree or title)
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 9/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 9/5/67
24c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery
24d. LOCATION (City, town, or county): Warren (State) Arkansas

DATE REC'D BY LOCAL REG.: 9-1-67
REGISTRAR'S SIGNATURE: R. Dave Thomason
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E-464

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

SEP 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 2 5 1993

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4202
Local Reg. No. 16
Reg. Dist. No. 320

RECEIVED
SEP 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 204 W. Idaho

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	RUTH	CORETTA	GOINS		9	5	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	married	2/7/1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	own home	Erie, Kansas	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Plass	----	----	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		544-12-7849A	Doris R. Cooper	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) C.V.A.
DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-2-, 1967, *to* 9-5-, 1967, *that I last saw the deceased alive on* 9-5-, 1967, *and that death occurred at* 6:20P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
344 T.B. McGrath MD	Weiser, Idaho	9/5/1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/9/1967	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-5-67	R. Dee Thomson	Marshall S. Dickerson Jr.	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

SEP 13 1967

Bureau of Vital Statistics

State File No. 4203
Local Reg. No. 17
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington 441 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): 526 E. 12th

3. NAME OF DECEASED (Type or Print): a. (First) ROLLIE b. (Middle) GAROLD 153 c. (Last) STRONG

4. DATE OF DEATH: (Month) 9 (Day) 7 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 2

8. DATE OF BIRTH: 12/5/1915

9. AGE (In years last birthday): 51 IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Ore-Ida.

11. BIRTHPLACE (State or foreign country): Norfolk, Nebraska

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Theodore Strong — BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: Pauline Mann — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 504-03-9699

17. INFORMANT'S OWN SIGNATURE: Fern A. Strong — ADDRESS: Weiser, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1637 Uremia Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen Arteriosclerosis — 4 yrs
DUE TO (c) Carcinoma of lung c. 1 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10/19, 1966 *to* 9/7, 1967 *that I last saw the deceased alive on* 9/7, 1967, *and that death occurred at* 8:50 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 3441
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 9/7/1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9/11/1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: 9-7-67
REGISTRAR'S SIGNATURE: R. Dan Thomason
25. EMBALMER: Marshall L. Dickerson
LICENSE NO.: E-464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 15 1967

SEP 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4204
Local Reg. No. 21
Reg. Dist. No. 320

RECEIVED SEP 21 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 441 Washington
b. CITY OR TOWN: Weiser
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 380 Oregon
b. COUNTY: 335 Baker
c. CITY OR TOWN: Huntington
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Eustace
b. (Middle): 153
c. (Last): Gay

4. DATE OF DEATH: (Month) 9 (Day) 11 (Year) 1967

5. SEX: male

6. COLOR OR RACE: caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: 1/12/1883

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): Morrellton, Arkansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hiram Berry Gay
BIRTHPLACE: -----

14. MOTHER'S MAIDEN NAME: Eleanor Steele
BIRTHPLACE: -----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: x [signature] ADDRESS: Huntington, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinomatosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ca - Rt Lung
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-3-, 1967, *to* 9-11, 1967, *that I last saw the deceased alive on* 9-11, 1967, *and that death occurred at* 5:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): 344 M.D. [signature]
23b. ADDRESS: Weiser, Idaho
23c. DATE SIGNED: 9/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 9/14/67
24c. NAME OF CEMETERY OR CREMATORY: Mt. Hope Cemetery
24d. LOCATION (City, town, or county) (State): Baker, Baker Oregon

DATE REC'D BY LOCAL REG.: 9-13-67
REGISTRAR'S SIGNATURE: R. Dan Thomason
25. EMBALMER: Marshall S. Dickenson Jr.
LICENSE NO.: E 464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 21 1967

OCT 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED SEP 19 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4205
Local Reg. No. 19
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Washington 441 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Washington 441
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): rural Monroe Creek

3. NAME OF DECEASED (Type or Print): a. (First) Donald b. (Middle) Edmund 153 c. (Last) Harlan

4. DATE OF DEATH: (Month) 9 (Day) 14 (Year) 1967

5. SEX: male
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: 11/9/1918
9. AGE (In years last birthday): 48 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): telephone repairman
10b. KIND OF BUSINESS OR INDUSTRY: 09 Mt. States
11. BIRTHPLACE (State or foreign country): Tracy, Minnesota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edmund Julian Harlan — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Lulu M. Allumbaugh — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW 2
16. SOCIAL SECURITY NO.: 1637
17. INFORMANT'S OWN SIGNATURE: x Rebecca A Harlan — ADDRESS: R2 Weiser Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma lung — 6 mo
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Extensive metastases

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/15, 1966, *to* 9/14, 1967, *that I last saw the deceased alive on* 9/14, 1967, *and that death occurred at* 12:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 344 [illegible] — 23b. ADDRESS: Weiser, Idaho — 23c. DATE SIGNED: 9/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 9/16/67
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest
24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: 9-16-67
REGISTRAR'S SIGNATURE: R. Dale Thomson
25. EMBALMER: Marshall D. Dickerson — LICENSE NO.: E 464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

SEP 21 1967
SEP 29 1967
SEP 6 1983

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RE Certificate of Death

STATE OF IDAHO

State File No. 4206
Local Reg. No. 25
Reg. Dist. No. 320

BIRTH NO.

OCT 23 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Washington 441 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 441 b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print) a. (First) CHRIS b. (Middle) G. 153 c. (Last) SKOURAS

4. DATE OF DEATH (Month) 9 (Day) 14 (Year) 1967

5. SEX Male

6. COLOR OR RACE Greek

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH 5/24/1967

9. AGE (In years last birthday) IF UNDER 1 YEAR Months 3 Days 20 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ----

10b. KIND OF BUSINESS OR INDUSTRY 02 ----

11. BIRTHPLACE (State or foreign country) Weiser, Idaho

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME George Skouras BIRTHPLACE Lamia, Greece

14. MOTHER'S MAIDEN NAME Mary Ayrafiotou BIRTHPLACE Greece

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. ----

17. INFORMANT'S OWN SIGNATURE George C. Skouras ADDRESS Weiser, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7545

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congenital Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-12- 1967, to 9-14- 1967, that I last saw the deceased alive on 9-14- 1967, and that death occurred at 4:30 Pm., from the causes and on the date stated above.

23a. SIGNATURE W.D. McGrath MD (Degree or title)

23b. ADDRESS Weiser, Idaho

23c. DATE SIGNED 9/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 9/16/1967

24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery

24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. 9/14/67

REGISTRAR'S SIGNATURE R. Dale Thomason

25. EMBALMER Marshall S. Dickerson Jr. LICENSE NO. E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: D-67-4967

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4207
Local Reg. No. 20
Reg. Dist. No. 320

BIRTH NO.

RECEIVED SEP 21 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington 44 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington 44
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): GRACE
b. (Middle): E. 153
c. (Last): BARTON

4. DATE OF DEATH: (Month) 9 (Day) 16 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 10/17/1908

9. AGE (In years last birthday): 58
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Weiser, Idaho

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: George Nuslein
BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: ----
BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Grace E. Barton
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C. V. A. 260 X

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Diabetes

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-13- 1967, *to* 9-16, 1967, *that I last saw the deceased alive on* 9-16, 1967, *and that death occurred at* 1:05 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 344 [signature]

23b. ADDRESS: Weiser, Idaho

23c. DATE SIGNED: 9/16/1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/19/1967

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: 9/16/67

REGISTRAR'S SIGNATURE: R. Dale Thomason

25. EMBALMER: Marshall S. Dickerson E. 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 08 19[illegible]

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4208
Local Reg. No. 22
Reg. Dist. No. 320

BIRTH NO.

RECEIVED SEP 27 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) JESSIE b. (Middle) NEWMAN c. (Last) WININGER

4. DATE OF DEATH: (Month) 9 (Day) 17 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: July 1, 1886

9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Weiser, Idaho

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Nathaniel Newman — BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: Sarah McCully — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 519-44-3495

17. INFORMANT'S OWN SIGNATURE: x Mrs L. Cirtha Bertram — ADDRESS: Portland, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Renal Failure — INTERVAL BETWEEN ONSET AND DEATH: 1yr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

593X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-29-67, 19__, *to* 9-13-67, 19__, *that I last saw the deceased alive on* 9-17-67, 19__, *and that death occurred at* 10:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas R. McDonnell, M. D. 667

23b. ADDRESS: Weiser, Idaho

23c. DATE SIGNED: 9/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/21/67

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: 9/17/67

REGISTRAR'S SIGNATURE: K. Dale Thomason

25. EMBALMER: Marshall S. Jackson Jr.

LICENSE NO.: E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4209
Local Reg. No. 23
Reg. Dist. No. 320

BIRTH NO.

RECEIVED SEP 27 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cambridge
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print): a. (First) CATHERINE b. (Middle) A. c. (Last) JONES

4. DATE OF DEATH: (Month) 9 (Day) 20 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	widowed 2	1/9/1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Orderville, Utah	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Crofts	----	----	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			X Elmer R. Jones	Cambridge

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Pulm Edema	8 h
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Chr. Cong Failure	6 mo
DUE TO (c)	Arteriosel Ht. Dis	10 yr
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/1, 1967, *to* 9/20, 1967, *that I last saw the deceased alive on* 9/20, 1967, *and that death occurred at* 9:45 a.m., *from the causes and on the date stated above.*

22c. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 344	Weiser, Idaho	9/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	9/23/1967	Basalt Cemetery	Basalt, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/20/67	R. Dale Thomason	Marshall S. Dickerson	E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 15 1978

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB - 2 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 6 1985

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 12 1986

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

JUN 3 2004

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

BIRTH NO. 67-2355

Certificate of Death

STATE OF IDAHO

State File No. 4210
Local Reg. No. 34
Reg. Dist. No. 320

RECEIVED OCT 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Washington 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE ----
b. COUNTY 000
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ----
d. STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print): a. (First) BABY b. (Middle) GIRL c. (Last) PAGE

4. DATE OF DEATH: (Month) 9 (Day) 21 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: 9/21/67

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours 3 Min. 30

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ---- 02

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Weiser, Idaho

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Danile Leo Page — BIRTHPLACE: Council, Idaho

14. MOTHER'S MAIDEN NAME: Judy Buell — BIRTHPLACE: Klamath Falls, Ore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. ---

17. INFORMANT'S OWN SIGNATURE x Leona Buell — ADDRESS Cambridge

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7766

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH 3½ d

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9 | 21 | 19 67, *to* 9 | 21 | 19 67, *that I last saw the deceased alive on* 9/21/19 67, *and that death occurred at* 1:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS: Weiser, Idaho

23c. DATE SIGNED: 9/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 9/23/1967

24c. NAME OF CEMETERY OR CREMATORY: Cambridge Cemetery

24d. LOCATION (City, town, or county) (State): Cambridge Idaho

DATE REC'D BY LOCAL REG.: 9/21/67

REGISTRAR'S SIGNATURE: R. Dan Thomson

25. EMBALMER: Marshall S. Dickerson

LICENSE NO.: E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Funeral Director 401 Idaho

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4211
Local Reg. No. 541
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 010
OCT 9 1967
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 812 3rd St 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 812 3rd St

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Virginia	Dare	Shoemaker	October 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	white	married 3	January 16, 1900	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elm, Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Calloway Epperly-Floyd, Virginia		Eliza Alloway Cannaday	Floyd, Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 562-03-8250-A
17. INFORMANT'S OWN SIGNATURE: William C Shoemaker ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 2018 Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: One year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): none
DUE TO (c): none

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Nov 1966	Hodgkins Disease (Surgery done In Oklahoma)	YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* February, 1967, *to* Sept 28, 1967, *that I last saw the deceased alive on* Sept 28, 1967, *and that death occurred at* 5:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Quentin C Howard MD 247	1401 Idaho St, Boise	Oct 5, 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/6/67	Terrace Lawn	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-9-67	Myrtle Palmer	Conway Grant	E-478

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: Relyea Mortuary

OCT 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Shawn [illegible]
401 No Orchard

Certificate of Death

State File No. 4212
Local Reg. No. 554
Reg. Dist. No. 370

BIRTH NO.

RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 OCT 13 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau of Vital
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 706 Highland Street

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): W
c. (Last): BROWN

4. DATE OF DEATH (Month) (Day) (Year): Oct 2, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: 12 - 29 - 1891
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Railroad-Mining
11. BIRTHPLACE (State or foreign country): White Clay, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Wm. C. Brown — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Sarah Simpson — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW 2 4
16. SOCIAL SECURITY NO.: 519-14-2322-A
17. INFORMANT'S OWN SIGNATURE: X Hazel E Brown — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3561

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Amyotrophic Lateral Sclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1959, *to* Oct 2, 1967, *that I last saw the deceased alive on* Oct 2, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 357 [signature] W
23b. ADDRESS: Boise Ida
23c. DATE SIGNED: 10-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/5/1967
24c. NAME OF CEMETERY OR CREMATORY: Joplin Cemetery
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 10-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E 478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 3 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4213
Local Reg. No. 152
Reg. Dist. No. 371

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011 OCT 11 1967 3-13
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): 15 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho.
b. COUNTY: 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 146 Addison West.

3. NAME OF DECEASED (Type or Print)
a. (First): Roy
b. (Middle): B
c. (Last): WEST.

4. DATE OF DEATH (Month) 10 (Day) 3 (Year) 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 3-14-94
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Chef 21
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Virgina
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: George L West. BIRTHPLACE: Virgina
14. MOTHER'S MAIDEN NAME: Sally Ryan BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1 4 451X
16. SOCIAL SECURITY NO.: 571 42 1458
17. INFORMANT'S OWN SIGNATURE John D. Stark ADDRESS: VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Emboli, multiple — INTERVAL BETWEEN ONSET AND DEATH: terminal

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiomegaly, cause undetermined with 2 months intra atrial thrombi.
DUE TO (c) Advanced atherosclerotic disease with 5 years. abdominal aortic aneurysm.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. ~~[illegible]~~ attended the deceased from 9-20, 1967, to 10-3, 1967, ~~[illegible]~~ and that death occurred at 1:40PM m., from the causes and on the date stated above.

23a. SIGNATURE M. G. Stromberg (Degree or title): M. G. STROMBERG, M.D. 597
23b. ADDRESS: VA Center, Boise, Idaho.
23c. DATE SIGNED: 10-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-10-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Jerry K. Lawson
LICENSE NO.: 522

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4214
Local Reg. No. 563
Reg. Dist. No. 370

Certificate of Death

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 26 Mesa Drive

3. NAME OF DECEASED (Type or Print)
a. (First): FRED
b. (Middle): LESLIE
c. (Last): SHEPARD

4. DATE OF DEATH (Month) (Day) (Year): October 3, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 1, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Groceryman 25
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Mapleton, North Dakota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William O. Shepard — BIRTHPLACE: Maine
14. MOTHER'S MAIDEN NAME: Martha A. — BIRTHPLACE: Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 542 52 7746
17. INFORMANT'S OWN SIGNATURE: Family Records, By: Jany J. Kronk — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5611

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia & Emphysema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Post op. incarcerated femoral hernia
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION: 9-19-67
19b. MAJOR FINDINGS OF OPERATION: Incarcerated femoral hernia
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-19, 1967, *to* 10-3, 1967, *that I last saw the deceased alive on* 10-3, 1967, *and that death occurred at* 1:40P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: C. C. Johnson 261 (Degree or title) M.D.
23b. ADDRESS: Boise Ida
23c. DATE SIGNED: 10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: W. Lawn Memorial Park
24d. LOCATION (City, town, or county) (State): Eugene Oregon

DATE REC'D BY LOCAL REG.: 10-19-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Jany J. Kronk — LICENSE NO. E-447

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Alsip Funeral Chapel
Alsip Fun...

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 10 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4215
Local Reg. No. 540
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 01 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4034 State St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Elvina	002	Fackler	October 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never married	Dec. 15, 1881	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Same	Winterset, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry H. Fackler	Wisconsin	Isabella Thomson	Ontario, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		X Viola Fackler	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — Interval between onset and death: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — Interval between onset and death: 20 yrs

DUE TO (c) Arterio Vascular Disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1963, 19___, *to* 3-Oct, 1967, *that I last saw the deceased alive on* 3 Oct, 1967, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	357	Boise Ida	10-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-6-1967	Morris Hill	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-6-67	Myrtle Palmer	Glen G. Siren	498

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McBratney-Alden-Waggoner Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 19 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4216
Local Reg. No. 562
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 5½ hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 38
b. COUNTY: Payette 4-06
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fruitland
d. STREET ADDRESS (If rural, give location): Route #1 5½Mi. SW Fruitland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Pearl	Lucille	Johanek	October 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	3 Married	March 25, 1921	46	-	--	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Blackfoot, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Cecil Ferrel	Iowa	Hannah Josephine Rys	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- - -		Charles P Johanek	Fruitland Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Stroke — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	none	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct 3, 19 67, *to* Oct 3, 19 67, *that I last saw the deceased alive on* 2 P.m. Oct 3 67 *and that death occurred at* 9:05 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
704 Clark Funderburk	401 Idaho, Boise, Idaho	10/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct 7, 1967	Park View Cemetery	New Plymouth Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-17-67	Myrtle Palmer	Keith M. Jensen	E-517

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

APR 30 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4217
Local Reg. No. 555
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 13 1967 Bureau

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Strawberry Glen Road

3. NAME OF DECEASED (Type or Print): a. (First) ERMA b. (Middle) IVON c. (Last) WOOD

4. DATE OF DEATH (Month) (Day) (Year): October 3, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 married
8. DATE OF BIRTH: August 12, 1922
9. AGE (In years last birthday): 45
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Cotter, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Beavers — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Bertha — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 429-30-2159
17. INFORMANT'S OWN SIGNATURE: Charles S. Wood — ADDRESS: 2003 W. State Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebellar hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Essential hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive cardiovascular disease

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 2, 1967, *to* Oct 3, 1967, *that I last saw the deceased alive on* Oct. 2, 1967, *and that death occurred at* 4 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Howard E. Allen 005 (Degree or title) M.D. 1
23b. ADDRESS: 220 N. 1st St.
23c. DATE SIGNED: Oct. 8, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Oct. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 10-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Howell Summers
LICENSE NO.: E-509
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4218
Local Reg. No. 539
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 6 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2901 State St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2901 State St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Alva	Daniel	Taylor	Oct. 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	2 Widowed	Feb. 24, 1888	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Retired	Montrose, Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George L. Taylor	Unknown	Alice Dorn	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	544-18-7562	Earl Alden	Boise

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Myocardial Infarction	Immediate
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Vascular Dis.	20 yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Emphysema--severe	10 Yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10/26/65, 19___, *to* 5/29/67, 19___, *that I last saw the deceased alive on* 5/29/67, 19___, *and that death occurred at* 11:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D. 516	1703 Hill Road	10/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-7-1967	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-6-67	Myrtle Palmer	Glen G. Siren	498

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME McBratney-Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 31 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4219
Local Reg. No. 546
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada — OCT 11 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 18 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3120 Crescent Rim Road

3. NAME OF DECEASED (Type or Print)
a. (First): RALPH
b. (Middle): L.
c. (Last): PARIS

4. DATE OF DEATH (Month) (Day) (Year): Oct. 5, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 11, 1902

9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Commissioner-Idaho Public Utilities

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Paris
BIRTHPLACE: Tennessee

14. MOTHER'S MAIDEN NAME: Nancy Blades
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-07-0849

17. INFORMANT'S OWN SIGNATURE: Beatrice H. Paris
ADDRESS: 3120 Crescent Rim, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH: 2 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cholecystitis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Jaundice

584.X

19a. DATE OF OPERATION: 9/23/67

19b. MAJOR FINDINGS OF OPERATION: Cholecystitis & stones; Pancreatitis

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9/19, 1967, *to* 10/5, 1967, *that I last saw the deceased alive on* 10/5, 1967, *and that death occurred at* 12:08 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard A. Forney, M.D.

23b. ADDRESS: 425 W. Bannock Boise, Idaho

23c. DATE SIGNED: 10/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-9-67

24c. NAME OF CEMETERY OR CREMATORY: Joplin Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-11-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Howell Mahaney

LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 20 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4220
Local Reg. No. 559
Reg. Dist. No. 870

BIRTH NO.

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 01 — 3-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 1 wk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 116 Winther Blvd.

3. NAME OF DECEASED (Type or Print): a. (First) Colleen b. (Middle) c. (Last) Moody

4. DATE OF DEATH: (Month) Oct. (Day) 6, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 1, 1931

9. AGE (In years last birthday): 36
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Kuna, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ivan Barker
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Irita Baugh
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: unk

17. INFORMANT'S OWN SIGNATURE: Norman L. Moody
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

17X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): METASTATIC CARCINOMA — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): CARCINOMA of CERVIX — 2 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~Sept 29~~ 1967, *to* Oct 6, 1967, *that I last saw the deceased alive on* Oct 6, 1967, *and that death occurred at* 3:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: C. J. Munson (Degree or title) MD
23b. ADDRESS: Boise Ida
23c. DATE SIGNED: 10-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-9-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 10-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature]
LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

OCT 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4221
Local Reg. No. 552
Reg. Dist. No. 270

BIRTH NO.

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 13 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 3220 N. 36th St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3220 N. 36th St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	TAYLOR	CHANDLER	Oct. 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Aug. 2, 1884	83		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Ranching	Sevierville, Tenn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John R. Chandler	Tenn.	Sarah Bailey	Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-52-3820	X Gladys E. Chandler	Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Heart Disease	2 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	with myocardial failure	?
DUE TO (c)	Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cancer of Prostate Gland with Metastasis	7 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 1946, *to* 10/6, 1967, *that I last saw the deceased alive on* 9/25, 1967, *and that death occurred at* 4:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D. 421	Boise	10/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 9, 1967	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-67	Myrtle Palmer	G. W. Waters [signature]	E-461

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cloverdale Funeral Home

OCT 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 27 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4222
Local Reg. No. 544
Reg. Dist. No. 370

Certificate of Death

RECEIVED
OCT 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Collister and State St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4306 Collister

3. NAME OF DECEASED (Type or Print)
a. (First): Robert
b. (Middle): Lee
c. (Last): Fessler

4. DATE OF DEATH (Month) (Day) (Year): Oct. 6, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married
8. DATE OF BIRTH: Nov. 8, 1945
9. AGE (In years last birthday): 21 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plant Worker 06
10b. KIND OF BUSINESS OR INDUSTRY: Ford Motor Co.
11. BIRTHPLACE (State or foreign country): Sonoma, California
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lawrence Fessler — BIRTHPLACE: Steele N. D.
14. MOTHER'S MAIDEN NAME: Mildred M. Carter — BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 563-62-7-78
17. INFORMANT'S OWN SIGNATURE: Nickie L. Fessler — ADDRESS: California Hayward

18. CAUSE OF DEATH 8234
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Severe Head & brain injuries — INTERVAL BETWEEN ONSET AND DEATH: Inst;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): High speed, & alcohol content 155 MG.
DUE TO (c): Hit a large Tree at side of Road. — Mins;

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 00
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 000
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 00 00 00 m. 0
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 2 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris 583 (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: 10=10=67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: Oct. 10, 67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-10-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUN 24 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4223
Local Reg. No. 543
Reg. Dist. No. 320

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 OCT 10 1967 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and Township): Boise
LENGTH OF STAY (in this place): 10 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1015 Hays

3. NAME OF DECEASED (Type or Print): a. (First) Lena b. (Middle) 332 c. (Last) Weatherly

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 2 Widowed

8. DATE OF BIRTH: April 22, 1872

9. AGE (In years last birthday): 95
IF UNDER 1 YEAR: Months / Days
IF UNDER 1 DAY: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mode Falks 71

10b. KIND OF BUSINESS OR INDUSTRY: Alterations

11. BIRTHPLACE (State or foreign country): Mt. Vernon, Oregon

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Robertson
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Emaline
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Lenice Archer
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* Sept 30, 1967, *that I last saw the deceased alive on* Sept 27, 19 67, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Max L. Bell 039 (Degree or title) M.D.

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 10/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 10, 1967

24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

24d. LOCATION (City, town, or county) (State): Ontario, Oregon

DATE REC'D BY LOCAL REG.: 10-9-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4224
Local Reg. No. 556
Reg. Dist. No. 570

RECEIVED OCT 17 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 7 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2220 Madison Street

3. NAME OF DECEASED (Type or Print): a. (First) Elizabeth b. (Middle) May c. (Last) Maloney

4. DATE OF DEATH: (Month) Oct. (Day) 7 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married

8. DATE OF BIRTH: May 5, 1903

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Jerrah England

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Parkin
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Ann Kaziahballs
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-09-3693

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: A Guy Maloney 2220 Madison Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3561

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Amyotrophic Lateral Sclerosis

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES XX NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 1, 1967 *to* Oct 7, 1967, *that I last saw the deceased alive on* Oct, 1967 *and that death occurred at* 5 PM m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A H Kyle MD 704

23b. ADDRESS: 701 Idaho St.

23c. DATE SIGNED: 10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 10, 1967

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery, Boise

24d. LOCATION (City, town, or county) (State): Idaho

DATE REC'D BY LOCAL REG.: 10-13-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Jack E. Walker

LICENSE NO.: E-483

FIRM NAME: SUMMERS FUNERAL HOMER

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4225
Local Reg. No. 545
Reg. Dist. No. 370

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

OCT 11 1967 3-14
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 14 da.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 300 Linden St.

3. NAME OF DECEASED (Type or Print)
a. (First): Montana
b. (Middle): Marie
c. (Last): McLeister

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married
8. DATE OF BIRTH: Sept. 13, 1966
9. AGE (In years last birthday): 31 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Adm. Assistant 26
10b. KIND OF BUSINESS OR INDUSTRY: Communications
11. BIRTHPLACE (State or foreign country): Kalispell, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Peter E. West-Montana
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Opal M. Brown-Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-34-5365
17. INFORMANT'S OWN SIGNATURE — ADDRESS: H V McLeister, 300 Linden St. Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

260X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Nephrosclerosis + abscess — 3 mo
DUE TO (c): Diabetes Mellitus — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Duodenal ulcer — 1 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1955, *to* 10-7, 1967, *that I last saw the deceased alive on* 10-7, 1967, *and that death occurred at* 6:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm D Forney 173 M D
23b. ADDRESS: 425 Bannock St Boise
23c. DATE SIGNED: 10-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
24b. DATE: 10/9/67
24c. NAME OF CEMETERY OR CREMATORY: Mt'n. View Crematory
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-9-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Leonard L. Mans
LICENSE NO.: E-443
FIRM NAME: MOUNTAIN VIEW FUNERAL HOME, BOISE

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 29 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4226
Local Reg. No. 549
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 12 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Hospital 005

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1715 N. 11th. Street

3. NAME OF DECEASED (Type or Print): a. (First) Harry; b. (Middle) C; c. (Last) Murphy

4. DATE OF DEATH: (Month) Oct. (Day) 7, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married

8. DATE OF BIRTH: Sept. 29, 1888

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): City Fireman 08

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Terre Haute, Indiana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Norman Allen Murphy — BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Alice Whitson — BIRTHPLACE: Whitson, Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-24-4480A

17. INFORMANT'S SIGNATURE: Nita Murphy — ADDRESS: 1715 No 11 St.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Stroke

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): atherosclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/19/67, 19__, *to* 10/7, 1967, *that I last saw the deceased alive on* 10/7, 19 6, *and that death occurred at* 2A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 054 (Degree or title): M.D

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 10/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-12-1967

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-12-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. FUNERAL DIRECTOR: R. E. Alden — ADDRESS: 299

McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

OCT 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP - 9 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4227
Local Reg. No. 155
Reg. Dist. No. 371

RECEIVED OCT 17 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 905 Nth 7th Street.

3. NAME OF DECEASED (Type or Print): a. (First) Howard b. (Middle) V c. (Last) FORREY

4. DATE OF DEATH: (Month) 10 (Day) 7 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married

8. DATE OF BIRTH: 12-14-93

9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Hospital Aide

10b. KIND OF BUSINESS OR INDUSTRY: 13 Same

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Albert C Forrey — BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Eemma J Croffoot — BIRTHPLACE: Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes — (If yes, give war or dates of service): WW I 3

16. SOCIAL SECURITY NO.: 530 09 6238

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: John D Forrey VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute pneumonitis	2 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Acute pulmonary infarction	3 days
DUE TO (c)		

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Thrombosis, right middle cerebral artery 5 days

463 X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that I~~ attended the deceased from 10-1, 19 67, to 10-7, 1967, ~~that I last saw the deceased on~~ and that death occurred at 5:06 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Robert C. Lewis, M.D. / ROBERT C LEWIS, M.D. 597

23b. ADDRESS: VA Center, Boise, Idaho.

23c. DATE SIGNED: 10-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 7, 1967

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 10-13-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: F. Willard Reed — LICENSE NO.: E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 9 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4228
Local Reg. No. 560
Reg. Dist. No. 370

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian rural
d. STREET ADDRESS (If rural, give location) Rt. 2

3. NAME OF DECEASED (Type or Print) a. (First) Mabel b. (Middle) A. c. (Last) Sovern

4. DATE OF DEATH (Month) (Day) (Year) Oct. 8, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2 Widowed
8. DATE OF BIRTH March 27, 1892
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Detroit, Michigan
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Blemline BIRTHPLACE Mich.
14. MOTHER'S MAIDEN NAME Louise Westfall BIRTHPLACE Mich.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unk.
17. INFORMANT'S OWN SIGNATURE Meridian ADDRESS Pearl Roam Rt #2

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1993 Carcinomatosis of Abdomen — INTERVAL BETWEEN ONSET AND DEATH Jan 1967

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION No Surgery this Cir
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 66, *to* Oct. 8, 19 67, *that I last saw the deceased alive on* 10-8-, 19 67, *and that death occurred at* 12:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 407 (Degree or title) 1
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-11, 1967
24c. NAME OF CEMETERY OR CREMATORY Meridian Cemetery
24d. LOCATION (City, town, or county) (State) Meridian, Idaho

DATE REC'D BY LOCAL REG. 10-16-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Geo Jerread
LICENSE NO. E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE,

DUTIES:

OCT 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4229
Local Reg. No. 154
Reg. Dist. No. 371

RECEIVED
OCT 13 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 2 ADA 011 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): One Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riggins
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Cyril	C	CRUSE	10	9	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	3 Married	3 25 21	46				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck Driver 27	Same	Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charlie Cruse	Unknown	May Sult.	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 2	519 012299	John C Cruse	VA Hospital Records, Boise, Idaho.

4201

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	INTERVAL BETWEEN ONSET AND DEATH
	Necrosis of Brain Stem	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*	DUE TO (b) Thrombosis of Basilar Artery	3 days
	DUE TO (c) Arteriosclerotic Coronary Thrombosis	3 days
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES XXX NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. [redacted] attended the deceased from 10-9, 1967, to 10-9, 1967, [redacted] and that death occurred at 7:45 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D. 597 /	VA Center, Boise, Idaho.	10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	Oct. 12, 1967	McCall Cemetery	McCall, Valley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-67	Myrtle Palmer	J. Richard Reed	E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 15 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4230
Local Reg. No. 350
Reg. Dist. No. 370

RECEIVED

OCT 13 1967

Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

LENGTH OF STAY (in this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 27th. & Jordan Streets 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada 011

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 814 Riviera Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Kenneth	James	Hickman	Oct. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	July 20, 1943	24				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Int.-Ext. Decorator	Same	New Castle, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Kenneth I. Hickman	Nebraska	Virginia Layman	Grand Island, Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Vietnam 08	533-40-6021	Kenneth J. Hickman	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Frontal Skull Fracture with brain penetration.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Basilar skull fracture

DUE TO (c) Motorcycle accident

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Minutes

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	27th. & Jordan	13 Boise	011 Ada	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
00	00	00	0	0		Motorcycle accident

DID NOT SEE ALIVE

22. I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. L. Davis 583	Coroner	3720 Meadow Dr., Boise	10/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/13/67	Cloverdale Memorial	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-12-67	Myrtle Palmer	A. E. Alden	299

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No.
Local Reg. No. 550
Reg. Dist. No. 370

BIRTH NO.

RECEIVED STATE OF IDAHO

OCT 12 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 27th. & Jordan Streets

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 814 Riviera Drive

3. NAME OF DECEASED (Type or Print): a. (First) Kenneth b. (Middle) James c. (Last) Hickman

4. DATE OF DEATH: (Month) Oct. (Day) 9, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: July 24, 1943

9. AGE (In years last birthday): 24
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Int.-Ext. Decorator

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): New Castle, Wyoming

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Kenneth I. Hickman
BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Virginia Layman Grand Island, Nebr.
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Viet Nam

16. SOCIAL SECURITY NO.: 533-40-6027

17. INFORMANT'S OWN SIGNATURE: Kenneth J Hickman
ADDRESS: Boise Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Frontal Skull fracture with brain penetration.
INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Basilar skull fracture
DUE TO (c) Motorcycle accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 27th. & Jordan
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Boise Ada Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): DID NOT SEE ALIVE
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Motorcycle accident

22. ~~I hereby certify that I attended~~ the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE: O. Paris (Degree or title): Coroner
23b. ADDRESS: 3720 Meadow Dr., Boise
23c. DATE SIGNED: 10/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/13/67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-12-67
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: A. E. Alden
LICENSE NO.: 299
FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 16 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 18 1967

NOV 6 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4231
Local Reg. No. 568
Reg. Dist. No. 370

Certificate of Death

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise,
d. STREET ADDRESS (If rural, give location): 2001 Grace Street

3. NAME OF DECEASED (Type or Print)
a. (First): HARRY
b. (Middle): J.
c. (Last): CRESWELL

4. DATE OF DEATH (Month) (Day) (Year): Oct. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married
8. DATE OF BIRTH: April 16, 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager, Investors
10b. KIND OF BUSINESS OR INDUSTRY: Diversified Services
11. BIRTHPLACE (State or foreign country): Reinbeck, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Alexander Creswell, Hudson, Iowa 26
BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Daisy Amanda Strohbehn, Reinbeck, Iowa
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-36-0627
17. INFORMANT'S OWN SIGNATURE: Myrtle M. Creswell
ADDRESS: 2001 Grace Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute myocardial infarction

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/15/, 1967, *to* ——, 19—, *that I last saw the deceased alive on* 9/15, 1967, *and that death occurred at* 3:20 PM *from the causes and on the date stated above.*

23a. SIGNATURE: [signature], M.D. 095 (Degree or title)
23b. ADDRESS: Boise, Ida
23c. DATE SIGNED: 10/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-13-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-23-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 2 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 13 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate; MAY 22 1981
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Cover to Jones Sr 1st National Bank Bldg 344 444

Certificate of Death

STATE OF IDAHO

State File No. 4232
Local Reg. No. 565
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 20 1967 000 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. ALPHONSUS 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: WYOMING 51
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BASIN
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): A.
c. (Last): DALY

4. DATE OF DEATH (Month) (Day) (Year): OCTOBER 10, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 MARRIED
8. DATE OF BIRTH: JULY 21, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: varied
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: George Daly — BIRTHPLACE: ~~Sc~~ Ireland
14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW 1 — (If yes, give war or dates of service): 3
16. SOCIAL SECURITY NO.: 519-05-8285 A
17. INFORMANT'S OWN SIGNATURE: x Mrs Faye Daly — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral adrenal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Acute Perforative Diverticulitis c̄ Peritonitis — 2 wks
DUE TO (c) E. Coli

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Status Post Gastrectomy 6 mo.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Peritonitis - Perforated Diverticulitis
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/22/67 *19*__, *to* 10/10, *19*67, *that I last saw the deceased alive on* 10/10, *19*67, *and that death occurred at* 12 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. Jones Sr 267
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 10/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/14/67
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county): Boise — (State): Idaho

DATE REC'D BY LOCAL REG.: 10-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant — Conway Grant
LICENSE NO.: E 478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

DUTIES:

OCT 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 16 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 20 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4233
Local Reg. No. 158
Reg. Dist. No. 371

BIRTH NO.

RECEIVED OCT 20 1967

1. PLACE OF DEATH
a. COUNTY: ADA 011 2-01
b. CITY OR TOWN: BOISE, IDAHO (Bureau of Township)
c. LENGTH OF STAY (In this place): 26 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA CENTER, BOISE, IDAHO. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 13
b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE.
d. STREET ADDRESS (If rural, give location): 1809 Nth 16th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	George	W	PECKHAM.		10	10	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	3 MARRIED m	5-17-97	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Fireman. 08	Same	Mich.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edgar Peckham	PA.	Elizabeth Russell.	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1	518 07 5597	John O. Stoops	VA HOSPITAL RECORDS, BOISE, IDAHO.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of prostate with multiple metastases. — INTERVAL BETWEEN ONSET AND DEATH: 3 3/4 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES XXX NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I hereby certify that I attended the deceased from 9-14, 19 67, to 10-10, 19 67, that death occurred at 5:10PM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. G. STROMBERG, M.D.	VA CENTER, BOISE, IDAHO.	10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/14/67	Cloverdale Memorial Park	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-19-67	Myrtle Palmer	G. W. Waters	E-461

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4234
Local Reg. No. 557
Reg. Dist. No. 370

RECEIVED OCT 17 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 621 N. Roosevelt

3. NAME OF DECEASED (Type or Print): a. (First) Clarence b. (Middle) Harold 003 c. (Last) Cullison

4. DATE OF DEATH: (Month) Oct. (Day) 11, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married

8. DATE OF BIRTH: Jan. 19, 1897

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Management 26

10b. KIND OF BUSINESS OR INDUSTRY: Auto Sales

11. BIRTHPLACE (State or foreign country): Afton, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Elmer Cullison
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Sarah Alice Slater
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-07-4250

17. INFORMANT'S OWN SIGNATURE: Mrs. S. H. Cullison
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 4201 Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Cerebral emboli — 12 days

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 29 Sept, 1967, *to* 12 Oct, 1967, *that I last saw the deceased alive on* 12 Oct, 1967, *and that death occurred at* 1130A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Norman D. Sawyer MD 780

23b. ADDRESS: 312 West Idaho - Boise

23c. DATE SIGNED: 13 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/14/67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-13-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Glen L. Sirin

LICENSE NO.: 498

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Ed Paris

Certificate of Death

STATE OF IDAHO

State File No. 4235
Local Reg. No. 153
Reg. Dist. No. 371

RECEIVED OCT 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) at Missel sight near Orchard, Idaho. | LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Near Orchard, Idaho. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho | b. COUNTY 245 Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Floyd | b. (Middle) Duane | c. (Last) Adam

4. DATE OF DEATH (Month) (Day) (Year) October 11, 1967

5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3 Married

8. DATE OF BIRTH May 3, 1945

9. AGE (In years last birthday) 22 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic on Construction 11

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) St. Paul, Minnesota.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Martin G. Adam | BIRTHPLACE American Falls, Ida.

14. MOTHER'S MAIDEN NAME Martha B. Kemmit | BIRTHPLACE Turtle Lake, North Dakota.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 519-50-1590

17. INFORMANT'S OWN SIGNATURE Martin G Adam | ADDRESS Gooding, Ida

9023

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed head and body. | INTERVAL BETWEEN ONSET AND DEATH Inst;

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) While working in Missile Silo fell 160 Ft; to Concrete, and ton of steel fell on him. | Seconds

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 20

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) 13 000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10 11 67 330P m.

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR? Fell 160 Ft; in Silo pit. Ton of steel fell in on him.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, to ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 330P m., *from the causes and on the date stated above.*

23a. SIGNATURE 583 Ed Paris (Degree or title) Coroner

23b. ADDRESS 3720 Meadow Drive, Boise.

23c. DATE SIGNED 10-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-16-67

24c. NAME OF CEMETERY OR CREMATORY Wendell Cemetery

24d. LOCATION (City, town, or county) (State) Wendell, Gooding, Idaho.

DATE REC'D BY LOCAL REG. 10-13-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Daniel G. Gibson | LICENSE NO. E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 23 1967

NOV 7 1967

MAR 19 1968

JUL 15 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4236
Local Reg. No. 561
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 18 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1800 Londoner

3. NAME OF DECEASED (Type or Print): a. (First) Felipe; b. (Middle) 003; c. (Last) Arriola

4. DATE OF DEATH (Month) (Day) (Year): Oct. 11, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married

8. DATE OF BIRTH: March 19, 1888

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 79

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Idaho Power 09

10b. KIND OF BUSINESS OR INDUSTRY: Idaho Power

11. BIRTHPLACE (State or foreign country): Motrico, Guipozcoa, Spain

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Domingo Arriola — BIRTHPLACE: Spain

14. MOTHER'S MAIDEN NAME: Francisca Imas — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: X Geo. D. Arriola — ADDRESS: Boise

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary heart disease, Uremia

DUE TO (c) Pulmonary congestion with condition

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Cor-pulmonale Senility, Glaucoma of left eye.

260X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan., 19 51, *to* Oct.10, 19 67, *that I last saw the deceased alive on* Oct. 10, 19 67, *and that death occurred at* 12:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 528 M. M. Thomas M.D. — **23b. ADDRESS**: 305 Fort St. Boise, Idaho — **23c. DATE SIGNED**: 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 10-13-67 — **24c. NAME OF CEMETERY OR CREMATORY**: Morris Hill — **24d. LOCATION** (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 10-17-67 — REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon E. Pearson — Eldon T. Pearson — LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Q. Mock

Certificate of Death

STATE OF IDAHO

State File No. 4237
Local Reg. No. 566
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011 000
b. CITY OR TOWN: BOISE
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: TREASURE VALLEY MANOR REST HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: ADA 011
c. CITY OR TOWN: BOISE
d. STREET ADDRESS (If rural, give location): 1420 LONGMONT

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	ESTELLA	293	NELSON BOREN		OCT.	12,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
FEMALE	WHITE	3 MARRIED	MAY 14, 1899	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown 00	Unknown	Denmark, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
UNKNOWN	UNKNOWN	UNKOWN	UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		519-05-8344A	Lee Boren	Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

350X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Parkinsonism — 15 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5, 1956, *to* 10-12, 1967, *that I last saw the deceased alive on* 10-5, 1967, *and that death occurred at* 4:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald 319	M D	Boise Idaho	10-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/16/67	Syringa Gardens	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-20-67	Myrtle Palmer	Jerry K. Lawson JERRY LAWSON	522

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Boruff

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 27 1967 Bureau of Vit. Stat.

State File No. 4238
Local Reg. No. 584
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (in this place) 5 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ADA COUNTY NURSING HOME 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY ADA 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 919 Marshall St.

3. NAME OF DECEASED (Type or Print) a. (First) MELINDA b. (Middle) BLOOMGREN c. (Last) PRESNALL

4. DATE OF DEATH (Month) (Day) (Year) OCT. 13, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2 widowed

8. DATE OF BIRTH April 17, 1883

9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) DANABORG, NEBRASKA

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John Bloomgren BIRTHPLACE Stockholm, Sweden

14. MOTHER'S MAIDEN NAME Mina Olsen BIRTHPLACE Oslo, Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Howell McClellan ADDRESS 919 Marshall

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1218 Carcinoma of cervix

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/8, 19 67, *to* 10/13, 19 67, *that I last saw the deceased alive on* 10/12, 19 67, *and that death occurred at* 1 P.A. m., *from the causes and on the date stated above.*

23a. SIGNATURE [illegible] 054 (Degree or title) M.D.

23b. ADDRESS Boise Idaho

23c. DATE SIGNED 10/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL

24b. DATE 10-14-67

24c. NAME OF CEMETERY OR CREMATORY St. Paul, Nebraska

24d. LOCATION (City, town, or county) St. Paul (State) Nebraska

DATE REC'D BY LOCAL REG. 10-26-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Jerry K. Lawson JERRY LAWSON LICENSE NO. 522

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended November 9, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4239
Local Reg. No. 358
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): few minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2208 Woodlawn

3. NAME OF DECEASED (Type or Print): a. (First) Mayme; b. (Middle) B.; c. (Last) Carter

4. DATE OF DEATH: (Month) October (Day) 13, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 2 Widowed

8. DATE OF BIRTH: Sept 11, 1888

9. AGE (In years last birthday): 79 | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Corsettier 21

10b. KIND OF BUSINESS OR INDUSTRY: Clothing

11. BIRTHPLACE (State or foreign country): Stratford, Ontario, Canada

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Neil McIntosh — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Mary Langdon — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-07-8181

17. INFORMANT'S OWN SIGNATURE: Colleen Bledsoe — ADDRESS: 1810 N. Hilton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8101

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Compound Fracture of Skull & Brain — INTERVAL BETWEEN ONSET AND DEATH: 1.40 Mins

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c): Her Auto was -

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Hit by Train Engine at a Crossing. 17 & River Sts, Boise

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 104

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street & rail crossing 13

21c. (CITY, TOWN, OR TOWNSHIP): Boise (COUNTY): Ada 011 (STATE): Idaho

21d. TIME OF INJURY (Month) Oct (Day) 13, (Year) 1967 (Hour) 7 a.m. 1

21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X] 2

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:40 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris, Coroner 583 (Degree or title) 4

23b. ADDRESS: 3720 Meadow Drive, Boise

23c. DATE SIGNED: 10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-16-67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-17-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Dowell D. Demaray

LICENSE NO.: E. 509

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

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(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho
County of Ada } ss.

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Mayme B. Carter (Name on Original Certificate) who died (Was Born or Died) on Oct 13, 1967 (Date of Event)
in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 21d-time of injury	October 12, 1967	October 13, 1967

Subscribed and sworn to before me this 9th day of November, 19 67
Notary Public, residing at Boise
My commission expires 9-10-70
(Seal)

Signed Edgar D. Paris
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)
372 Meadow Dr. Boise
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Ada } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 9th day of November, 19 67
Notary Public, residing at Boise
My commission expires 9-10-70
(Seal)

Signed Lowell V. Manary
(Signature of Any Credible Person)
1205 West Bannock Boise, Ida
(Street Address, City, State)

FORM DH 60-155

NOTARY PUBLIC
STATE OF IDAHO

NOTARY PUBLIC
STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 558
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada
OCT 18 1967
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) few minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 2208 Woodlawn

3. NAME OF DECEASED (Type or Print) a. (First) MAYME b. (Middle) B. c. (Last) CARTER

4. DATE OF DEATH (Month) (Day) (Year) October 13, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed

8. DATE OF BIRTH Sept. 11, 1888

9. AGE (In years last birthday) 79
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) corsettier

10b. KIND OF BUSINESS OR INDUSTRY clothing

11. BIRTHPLACE (State or foreign country) Stratford, Ontario, Canada

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Neil McIntosh
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Mary Langdon
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 518-07-8181

17. INFORMANT'S OWN SIGNATURE + Evelyn Bledsoe
ADDRESS 1810 N. Hilton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Compound Fracture of Skull & Brain.
INTERVAL BETWEEN ONSET AND DEATH: I.40 Mins

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Her Auto was-

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hit by Train Engine at a Crossing. I7 & River Sts; Boise.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street & rail crossing

21c. (CITY, TOWN, OR TOWNSHIP) Boise (COUNTY) Ada (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 12, '67 7a. m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did No t 19 Sep to Alive, 19, *that I last saw the deceased alive on* , 19, *and that death occurred at* 840Aa m., *from the causes and on the date stated above.*

23a. SIGNATURE
(Degree or title) Coroner

23b. ADDRESS 3720 Meadow Drive, Boise.

23c. DATE SIGNED 10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-16-67

24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery

24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 10-17-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER

LICENSE NO. E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 9 - 1967

MAY 15 1968

MAY 21 1968

AUG 5 1983

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

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ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4240
Local Reg. No. 553
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 13 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Burns
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Imperial Plaza 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Imperial Plaza

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Neil	N.	Smalkin	October 13, 67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 8, 1940	27				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Lawyer 14	Law	Baltimore, Maryland	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Smalkin	Maryland	Gertrude Jacobs	Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.		X Mrs. Neil N. Smalkin	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apparent Coronary Arteriosclerotic. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Had severe Ulcer Operation in May 67. Dry Cough, apparent some Emphysema Condition. — Months Mins;

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. died in sleep.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 Eldon Pearson	Coroner	3720 Meadow Drive, Boise,	10-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10-13-67	Maryland Cemetery	Baltimore, Maryland

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-67	Myrtle Palmer	Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Gibson Funeral Home

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 24 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 30 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 20 1979

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PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 26 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4241
Local Reg. No. 163
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 2-01
b. CITY OR TOWN: Boise, Idaho.
c. LENGTH OF STAY (in this place): 30 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 070
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bellevue.
d. STREET ADDRESS (If rural, give location): Box 222

3. NAME OF DECEASED (Type or Print): a. (First) James; b. (Middle) NMI; c. (Last) HARDIE.

4. DATE OF DEATH: (Month) 10; (Day) 14; (Year) 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 8-5-90
9. AGE (In years last birthday): 77 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 06
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Scotland.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Christopher Hardie — BIRTHPLACE: Scotland.
14. MOTHER'S MAIDEN NAME: Janet Patterson. — BIRTHPLACE: Scotland
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 519 46 3672
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: VA Hospital Records, Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma, prostate, with extensive boney metastases — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Bronchopneumonia — 3 days

19a. DATE OF OPERATION: 10-10-67
19b. MAJOR FINDINGS OF OPERATION: Bladder neck obstruction due to carcinoma prostate
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) VA m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that I~~ attended the deceased from 9-14, 19 67 to 10-14, 19 67, ~~that I last saw the deceased alive on~~, and that death occurred at 11:20 PM., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Wm. W. Lawson — W. W. LAWSON, M.D. 597
23b. ADDRESS: VA CENTER, BOISE, IDAHO.
23c. DATE SIGNED: 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10-16-67
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: 10-25-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

MAY - 6 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4242
Local Reg. No. 161
Reg. Dist. No. 371

RECEIVED OCT 24 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
LENGTH OF STAY (in this place): 39 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 21 So. Roosevelt Street.

3. NAME OF DECEASED (Type or Print)
a. (First): Lee
b. (Middle): Wayne 004
c. (Last): LUNDY.

4. DATE OF DEATH: (Month) 10 (Day) 14 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 5-16-12

9. AGE (In years last birthday): 55
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Work

10b. KIND OF BUSINESS OR INDUSTRY: Labor Same

11. BIRTHPLACE (State or foreign country): Wyo.

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Charles Lundy
BIRTHPLACE: Ky.

14. MOTHER'S MAIDEN NAME: Effie Richardson
BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW 2

16. SOCIAL SECURITY NO.: 520 05 2850

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: John D Stark
VA Hospital Records, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Alveolar cell carcinoma left lung possible — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Sept. 12, 1967

19b. MAJOR FINDINGS OF OPERATION: Inflammatory and/or lesion left lung, lower lobe

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?

22. I hereby certify that I attended the deceased from 9-5, 19 67, to 10-14, 19 67, and that death occurred at 6:40PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): W. G. CROOKSTON, M.D. 597

23b. ADDRESS: VA Center, Boise, Idaho

23c. DATE SIGNED: 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 10-16-67

24c. NAME OF CEMETERY OR CREMATORY: Wheatland

24d. LOCATION (City, town, or county) (State): Wheatland, Wyoming

DATE REC'D BY LOCAL REG.: 10-23-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Strang

LICENSE NO.: E478

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 22 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 1243
Local Reg. No. 164
Reg. Dist. No. 371

RECEIVED OCT 31 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): 26 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon. 38
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ontario
d. STREET ADDRESS (If rural, give location): 170 NE, 2nd Street.

3. NAME OF DECEASED (Type or Print): a. (First) Elbert b. (Middle) V 004 c. (Last) LEMONS.

4. DATE OF DEATH: (Month) 10 (Day) 14 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 11-30-91

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Oregon

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: Wes Lemons. BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Laura Engles. BIRTHPLACE: Ill Stark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I 3

16. SOCIAL SECURITY NO.: 721 14 3687

17. INFORMANT'S OWN SIGNATURE: John Stark ADDRESS: VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inanition — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of rectum or prostate — 2 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1992

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that I~~ attended the deceased from 9-18, 19 67, to 10-14, 19 67, ~~that I last saw the deceased alive on~~ and that death occurred at 4 AM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or Title): J. K. HELFERTY, M.D. 597 — **23b. ADDRESS**: VA Center, Boise, Idaho. — **23c. DATE SIGNED**: 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem-burial — **24b. DATE**: 10/10/67 — **24c. NAME OF CEMETERY OR CREMATORY**: EVERGREEN CEMETERY — **24d. LOCATION** (City, town, or county) (State): Ontario, Oregon

DATE REC'D BY LOCAL REG.: 10-30-67 — REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Robert V. Bertelsen — LICENSE NO.: Ore 187
FIRM NAME: Bertelsen-Lienkaemper

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4244
Local Reg. No. 571
Reg. Dist. No. 70

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada OCT 24 1967 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau of Vital Statistics
c. LENGTH OF STAY (If in this place): 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 912 North 10th Street

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLOTTE
b. (Middle): 332
c. (Last): LEMMER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 14, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 24, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): England Bennifield, N. Hampshire
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Freeman — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Margaret Holman — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 542-07-4988
17. INFORMANT'S OWN SIGNATURE: Thelma L. Mudd — ADDRESS: 1707 Beach St. Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart Disease Coronary — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — ?
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: P.O. Resection of Sigmoid Colon — Carcinoma

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Carcinoma Sigmoid
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-27, 1965 *to* Oct 14, 1967, *that I last saw the deceased alive on* Oct 8, 1967, *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl B. Smithson MD 484
23b. ADDRESS: 309 Eastman Bldg., Boise, Idaho
23c. DATE SIGNED: 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-17-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-23-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Lowell D. Demaray — LICENSE NO.: E-509
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 1 6 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended November 8, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4245
Local Reg. No. 156
Reg. Dist. No. 371

BIRTH NO.*

1. PLACE OF DEATH
a. COUNTY: Ada 010 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 18 miles East of Boise Interstate 80 N. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 711 Washington

3. NAME OF DECEASED (Type or Print): a. (First) Henry; b. (Middle) Lee; c. (Last) Tonning

4. DATE OF DEATH: (Month) October (Day) 14, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 22, 1940

9. AGE (In years last birthday): 27
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ridder 08

10b. KIND OF BUSINESS OR INDUSTRY: Veterans Admin.

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Kenneth Tonning
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Helen Borgman
BIRTHPLACE: Weiser, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): 1957 to 1961

16. SOCIAL SECURITY NO.: 518-40-4296

17. INFORMANT'S OWN SIGNATURE: Harvey H. Springer
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken Neck — INTERVAL BETWEEN ONSET AND DEATH: Inst.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Alcohol Lab test, 300 MG.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 000

21d. TIME OF INJURY (Month) 10-14-67 (Day) (Year) (Hour) 11 P m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2

21f. HOW DID INJURY OCCUR? In auto that rolled landed on its top. skidded 400 ft

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris, Coroner (Degree or title) 583 4

23b. ADDRESS: 3720 Meadow Drive, Boise

23c. DATE SIGNED: 10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1

24b. DATE: Oct 18, 1967

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-16-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson

LICENSE NO.: E.512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 28 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED NOV 8 1967 Bureau of Vital Statistics

State of Idaho
County of Ada } ss.

Certificate No.

Date Filed October 19, 1967

The undersigned does solemnly swear that certain facts on the certificate of (Birth or Death)

for Henry Lee Tonning (Name on Original Certificate) who died (Was Born or Died) on October 15, 1967 (Date of Event)

in 18 mi. E. of Boise on 80 No. (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
First name	Henery Lee Tonning	Henry Lee Tonning
Date of death	October 15, 1967	October 14, 1967

Subscribed and sworn to before me this 7 day of November, 1967

Hazel L. Hurlburt
Notary Public, residing at Eagle Idaho
My commission expires Sept 28 1968
(Seal)

Signed Elden T. Pearson
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Ada } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 7 day of November, 1967

Corinne Gilbert
Notary Public, residing at Boise, Idaho
My commission expires 8-4-68
(Seal)

Signed Edgar D. Paris
(Signature of Any Credible Person)

3720 Meadowlark Dr Boise
(Street Address, City, State)

FORM DN 60-155

Idaho

Ada

October 19, 1967

Henry Lee Tonning died October 15, 1967

L. E. of Boise on 80 Mo.

First name Henry Lee Tonning Henry Lee Tonning

Date of death October 15, 1967 October 14, 1967

Sheet number [illegible]

[illegible] AFFIDAVIT OF [illegible] CAUSION

County of

The [illegible] forth above [illegible] that they

[illegible]

Seal

Form [illegible]

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 36-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 156
Reg. Dist. No. 371

BIRTH NO.

OCT 19 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
LENGTH OF STAY (in this place): Int.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 10 Miles East of Boise Interstate 80 N.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 711 Washington

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Henery	Lee	Tonning	Oct. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	May 22, 1940	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ridder	Veterans Admin.	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Kenneth Tonning	Unknown	Helen Borgman	Weiser, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	1957 to 1961	518-40-4296	Harvey H Tonning	Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken Neck.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Alcohol Lab test, 300 MG.

INTERVAL BETWEEN ONSET AND DEATH: Inst;

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
10- 14 67 IIP m.		In Auto.that Rolled landed on its top.skidded 400 Ft

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* IIP m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Davis	Coroner	3720 Meadow Drive.Boise.	10-16th 67.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 18, 67	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-16-67	Myrtle Palmer by Helen Olsen	Eldon T. Pearson	E-512

Federal Security Agency
United States Public Health Service
Form DH-630(2)

FIRM NAME: Gibson Funeral Home

OCT 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 28 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4246
Local Reg. No. 576
Reg. Dist. No. 370

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 3
b. COUNTY: Washington 440
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Midvale
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): A.
c. (Last): POWELL

4. DATE OF DEATH (Month) (Day) (Year): Oct. 15 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0
8. DATE OF BIRTH: July 10, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Price, Utah
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: ----
BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: ----
BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 524-05-4389A
17. INFORMANT'S OWN SIGNATURE: Blanche Middleson
ADDRESS: Midvale, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): myocardial Infarction
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fractured hip

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 3:45p. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Loren D. Blickenstaff 783 MD
23b. ADDRESS: 1015 N. 8th St., Boise, Ida.
23c. DATE SIGNED: 10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Bur. Removal 3
24b. DATE: Oct. 15, 1967
24c. NAME OF CEMETERY OR CREMATORY: Eastside Cemetery
24d. LOCATION (City, town, or county) (State): Midvale Idaho

DATE REC'D BY LOCAL REG.: 10-25-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: R. Dave Thomason
LICENSE NO.: E-388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 8 1967

JAN 15 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4247
Local Reg. No. 580
Reg. Dist. No. 370

RECEIVED OCT 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN: Boise 000
LENGTH OF STAY (If this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 070 Blaine
c. CITY OR TOWN: Hailey
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) James b. (Middle) Edward c. (Last) Peck

4. DATE OF DEATH (Month) (Day) (Year): Oct. 15, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Jan. 21, 1950

9. AGE (In years last birthday): 17 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hailey, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas E. Peck — BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Mary Jane Liechliter — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: George E. Kershner — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 88554 Extra dural hematoma — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Severe head injury

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Pt. moribund upon admission

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: no surgery performed

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10 15-67 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Auto accident

22. *I hereby certify that I attended the deceased from* 10-15 , 1967, *to* 10-15- , 1967, *that I last saw the deceased alive on* 10-15-67 10 , *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 28 Ward Ryker M.D.

23b. ADDRESS: 616 Eastman

23c. DATE SIGNED: 10/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 18, 1967

24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery

24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: 10-25-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Fred E. Walker — LICENSE NO.: E-483

FIRM NAME: SUMMERS

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Mason

Certificate of Death

STATE OF IDAHO

State File No. 4248
Local Reg. No. 567
Reg. Dist. No. 370

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. LUKE'S HOSPITAL 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: ADA 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 2003 VISTA AVE.

3. NAME OF DECEASED (Type or Print): a. (First) J. b. (Middle) ROSS c. (Last) JOLLEY

4. DATE OF DEATH (Month) (Day) (Year): Oct 15, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Nov. 17, 1902

9. AGE (In years last birthday): 64 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Meat Mkt Owner 22

10b. KIND OF BUSINESS OR INDUSTRY: Meat cutting

11. BIRTHPLACE (State or foreign country): Tropic, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Joseph Jolley — BIRTHPLACE: Cincnatii, Ohio

14. MOTHER'S MAIDEN NAME: Isabelle Culter — BIRTHPLACE: Sacksville, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-32-8999

17. INFORMANT'S OWN SIGNATURE: Merry R. Jolley — ADDRESS: 2003 Vista Ave.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Essential Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Benign Prostatic Hypertrophy

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October, 1963, *to* October 15, 1967, *that I last saw the deceased alive on* Oct. 14, 1967, *and that death occurred at* 12:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ted Mason (Degree or title) 333
23b. ADDRESS: 808 Valencia Dr. Boise Idaho
23c. DATE SIGNED: 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: October 17, 1967
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 10-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E 478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 19 2000

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4249
Local Reg. No. 159
Reg. Dist. No. 371

RECEIVED OCT 20 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada. 011 — 3-14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of township): Boise, Idaho
c. LENGTH OF STAY (in this place): 14 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho. b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 712½ Idaho Street.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Wilbur	P	KARR.	10	15	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 27	6-11-95	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Prison Guard.
10b. KIND OF BUSINESS OR INDUSTRY: 08 Same
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Jobe Karr. BIRTHPLACE: Ohio.
14. MOTHER'S MAIDEN NAME: Anna Bobson. BIRTHPLACE: Canada.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 513 14 4093
17. INFORMANT'S OWN SIGNATURE: John E. Karr ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary infarction, massive — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture right hip with open reduction — 12 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-3-67	Intertrochanteric fracture right hip	YES XXX NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I attended the deceased from 10-1, 1967, to 10-15, 1967, [illegible] and that death occurred at 7:30 PM m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W.G. CROCKSTON, M.D. 597		VA CENTER, BOISE, IDAHO.	10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-18-67	Morris Hill	Boise Ada Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-19-67	Myrtle Palmer	Eldon T. Pearson Eldon T. Pearson	E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4250
Local Reg. No. 564
Reg. Dist. No. 370

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1512 Bradway

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Deborah	Ann	Strong	Oct. 16 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	Oct. 12, 1966	1 Yr.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert L. Strong	Payette, Idaho	Marie C. Frisbie	Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	No	x Robert L. Strong	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2893

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Bronchopneumonia	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Cystic Fibrosis	congenital
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	adrenal hypoplasia	congenital

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* See Reverse *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Jay T. Swinehart MD	519 200 E Bannock St	10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/18/67	Cloverdale Park	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-19-67	Myrtle Palmer	Alden Waggoner	E-460

FIRM NAME: McBratney Alden Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 216.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Patient under the care of my associate, Dr Wm Venning from January 1967 until death. Was dead on arrival at St Lukes 5:30 AM 10-16-67 [illegible]

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4251
Local Reg. No. 577
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 26 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Roy; b. (Middle) Robert; c. (Last) Robertson

4. DATE OF DEATH (Month) (Day) (Year): Oct. 16, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: March 29, 1949

9. AGE (In years last birthday): 18
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sun Valley, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Calvin Robertson
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Edith Bushnell
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Calvin C. Robertson
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Extensive brain damage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Skull fracture (

DUE TO (c) car accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 10/15/67

19b. MAJOR FINDINGS OF OPERATION: Cerebral edema

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 00

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 00 00 00 m. 01

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY Ooccur?: Per Coroner's report.

22. *I hereby certify that I attended the deceased from* 10-15-67, 19__, *to* 10-16-67, 19__, *that I last saw the deceased alive on* 10-16-67, 19__, *and that death occurred at* 2:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edward Smith MD

23b. ADDRESS: 616 Eastman Bldg

23c. DATE SIGNED: 10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 18, 1967

24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery

24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: 10-25-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Fred E. Walker

LICENSE NO.: E-483

FIRM NAME: SUMMERS

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 9 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4252
Local Reg. No. 569
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 24 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 3-09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1511 N. 23rd. St.

3. NAME OF DECEASED (Type or Print)
a. (First): EUVA
b. (Middle): H.
c. (Last): MORGAN

4. DATE OF DEATH (Month) (Day) (Year): Oct. 17, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married
8. DATE OF BIRTH: Dec. 9, 1889
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Goldendale, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Hause — BIRTHPLACE: Ky.
14. MOTHER'S MAIDEN NAME: Louvenia P. Lyon — BIRTHPLACE: Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-07-2930
17. INFORMANT'S OWN SIGNATURE: Arthur L. Morgan — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fracture pelvis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 00
21c. (CITY, TOWN, OR TOWNSHIP) 011 (COUNTY) (STATE): 13 Boise Ada Ida.
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 10 67 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Struck by Car

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* Oct 17, 1967, *that I last saw the deceased alive on* Oct 17, 1967, *and that death occurred at* 9:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James H. Hawley M.D. 216
23b. ADDRESS: 550 S Latah
23c. DATE SIGNED: 19 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 10/20/67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 10-19-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters — LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 25 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 15 1974

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4253
Local Reg. No. 162
Reg. Dist. No. 371

Certificate of Death

RECEIVED
OCT 24 1967
Bureau of

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 010 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian rural
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 3 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian rural
d. STREET ADDRESS (If rural, give location): Rt. 3

3. NAME OF DECEASED (Type or Print)
a. (First): Curtis
b. (Middle): D.
c. (Last): Corey

4. DATE OF DEATH (Month) (Day) (Year): Oct. 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 9, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Meridian, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: W. A. Corey — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Olive Ellis — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-24-8061
17. INFORMANT'S OWN SIGNATURE: Emma D. Corey — ADDRESS: Rt. 3 Meridian

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Never, *19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 5:45 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Lee Bulley MD 624 (Degree or title)
23b. ADDRESS: 925 E 1st Meridian
23c. DATE SIGNED: 18 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-21-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-24-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo. Jerrod
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-9447 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4254
Local Reg. No. 583
Reg. Dist. No. 370

BIRTH NO.

OCT 27 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 010 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Boise
d. STREET ADDRESS (If rural, give location): Route #1 Boise

3. NAME OF DECEASED (Type or Print)
a. (First): Dee
b. (Middle): Ann
c. (Last): Lamkey

4. DATE OF DEATH (Month) 10 (Day) 17 (Year) 67

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 10-17-1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours 1 Min. 46

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02
10b. KIND OF BUSINESS OR INDUSTRY: Child
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ronald Lamkey
BIRTHPLACE: Richfield, Idaho
14. MOTHER'S MAIDEN NAME: Donna Gardiner
BIRTHPLACE: Rigby, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Mrs Ronald Lamkey
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

776X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity & Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-17, 1967, *to* 10-18, 1967, *that I last saw the deceased alive on* 10-18, 1967, *and that death occurred at* 11:56 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl M. Johnston 264 MD
23b. ADDRESS: 846 Fox Cosgrove Bldg Boise
23c. DATE SIGNED: 10/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-20-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-25-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Elad M. Sears
LICENSE NO.: E-460

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McBratney-Alden-Waggoner

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-9448
BIRTH NO.

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 27 1967
Bureau of Vital Statistics

State File No. 4255
Local Reg. No. 582
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY: Ada 01 — 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Boise
d. STREET ADDRESS (If rural, give location): Route # 1 Boise

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lee	Ann	Lamkey	10	18	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	10-17-67				2	31

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02
10b. KIND OF BUSINESS OR INDUSTRY: Child
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ronald Lamkey — BIRTHPLACE: Richfield, Idaho
14. MOTHER'S MAIDEN NAME: Donna Gardiner — BIRTHPLACE: Rigby, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Mrs Ronald Lamkey — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 776X Prematurity & Immaturity — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-17, 1967, *to* 10-18, 1967, *that I last saw the deceased alive on* 10-18, 1967, *and that death occurred at* 12:35 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] (Degree or title)
23b. ADDRESS: 848 Ira Cross Ben Boise
23c. DATE SIGNED: 10/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-20-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 10-25-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Frank D Lease
LICENSE NO.: E-460

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4256
Local Reg. No. 370
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 24 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1331 Yellowstone

3. NAME OF DECEASED (Type or Print)
a. (First): Winona
b. (Middle): N
c. (Last): Myers

4. DATE OF DEATH (Month) (Day) (Year): Oct 18, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married
8. DATE OF BIRTH: Aug. 4, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Preston, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown
BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-20-0098
17. INFORMANT'S OWN SIGNATURE: M. Russell Losch
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: yes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): also pulmonary fibrosis — yes

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Cerebral vascular thrombosis — 10 days

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-2-67, 19__, *to* 10-18-, 1967, *that I last saw the deceased alive on* 10-18, 1967, *and that death occurred at* 9:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. D. Forney 173 (Degree or title): M.D.
23b. ADDRESS: 425 Bannock Boi
23c. DATE SIGNED: 10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10-19-67
24c. NAME OF CEMETERY OR CREMATORY: Pocatello City Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: 10-19-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Elah [illegible]
LICENSE NO.: E-460
FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

G BAKER
121 E. Idaho

Certificate of Death

STATE OF IDAHO

State File No. 4257
Local Reg. No. 589
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
OCT 31 1967
Bureau of Vital Statistics

1-22

1. PLACE OF DEATH
a. COUNTY Ada 001
b. CITY OR TOWN Boise, Idaho
LENGTH OF STAY (in this place) 22 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 001
c. CITY OR TOWN Boise,
d. STREET ADDRESS 2024 Hervey

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
NELL	HELEN	GASKELL	10	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	3 Married	February 7, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Licened Practal Nurse 13	Private Nursing	Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edward Tullock	Oklahoma	Lutie Lannie Byran	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		Unknown	X Norman Gaskell	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7750

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
019 George R Baker MD	1-	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/21/67	Dry Creek Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-31-67	Myrtle Palmer	Jerry K. Lawson E	522

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 18 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4258
Local Reg. No. 572
Reg. Dist. No. 370

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 Ada OCT 24 1967 2-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 5 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1202 North 20th Street

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): HUNTER 292
c. (Last): STEWART

4. DATE OF DEATH (Month) (Day) (Year): Oct. 19, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Jan. 8, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Companion 30
10b. KIND OF BUSINESS OR INDUSTRY: Aged People
11. BIRTHPLACE (State or foreign country): Bennettesville, N. Y.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charlie Stewart — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: June McMillen — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 541-36-5979
17. INFORMANT'S OWN SIGNATURE: Agnes A Spofford — ADDRESS: 1202 N. 20th Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Inanition — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Metastatic liver carcinoma
DUE TO (c): Carcinoma of rectosigmoid

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

154X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/3/1961, *to* 10/19, 1967, *that I last saw the deceased alive on* 10/19, 1967, *and that death occurred at* 5:15 PM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 005 Howard E. Allen, M.D.
23b. ADDRESS: 220 N. 1st St.
23c. DATE SIGNED: 10/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 10-23-67
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Memorial
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-23-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4259
Local Reg. No. 595
Reg. Dist. No. 370

RECEIVED NOV 3 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place): 1day

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN: Emmett
d. STREET ADDRESS (If rural, give location): 1108 East Phillips St

d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alph. Hosp. 003

3. NAME OF DECEASED (Type or Print): a. (First) Mortimer; b. (Middle) Joseph; c. (Last) Phillips

4. DATE OF DEATH (Month) (Day) (Year): Oct. 19, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Jan. 31, 1890
9. AGE (In years last birthday): 77 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: auto
11. BIRTHPLACE (State or foreign country): Woodriver, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel E. Phillips — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Esther Cooley — BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 36 0037A
17. INFORMANT'S OWN SIGNATURE: X Mrs M. J. Phillips — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

20/X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hodgkins' Sarcoma
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Extensive malignancy involving all abdominal organs.
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-18, 1967, *to* 10-19, 1967, *that I last saw the deceased alive on* 10-19, 1967, *and that death occurred at* 3p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. C. Johnson 261 (Degree or title) MD
23b. ADDRESS: 425 W. Bannock, Boise, Idaho, 83702
23c. DATE SIGNED: 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Oct. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett Idaho

DATE REC'D BY LOCAL REG.: 11-1-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E392
FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4260
Local Reg. No. 5-78
Reg. Dist. No. 270

BIRTH NO.

RECEIVED OCT 26 1967 Bureau of Vital Statistics 3-10

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1209 North Nineteenth

3. NAME OF DECEASED (Type or Print): a. (First) RALPH b. (Middle) S. c. (Last) BRISTOL

4. DATE OF DEATH (Month) (Day) (Year): October 19, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Sept. 20, 1895

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): assistant director

10b. KIND OF BUSINESS OR INDUSTRY: reclamation

11. BIRTHPLACE (State or foreign country): Howell, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George E. Bristol
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Mamie Marker
BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W. W. One

16. SOCIAL SECURITY NO.: 518-46-7350

17. INFORMANT'S OWN SIGNATURE: Carol N. Bristol ADDRESS: 209 N. 19th Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Carcinoma Prostate — 2 days

DUE TO (c): Arthritis — 3 days

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Coronary Failure — 2 wks

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/10, 1961, *to* 10/19, 1967, *that I last saw the deceased alive on* 10/18, 1967, *and that death occurred at* 8:40a m., *from the causes and on the date stated above.*

23a. SIGNATURE: M. Jessen, MD (Degree or title)

23b. ADDRESS: Boise

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Oct. 21, 1967

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 10-25-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Howell W. Summers

LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 31 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 10 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED NOV 1 1967 Bureau of Vital Sta.

STATE OF IDAHO

State File No. 4261
Local Reg. No. 165
Reg. Dist. No. 371
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 01 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): One Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho. b. COUNTY: 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Sun Set Nursing Home, Boise, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) Jens b. (Middle) C. c. (Last) Iverson

4. DATE OF DEATH: (Month) Oct. (Day) 19 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 2-24-89

9. AGE (In years last birthday): 78 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Denmark.

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: James Iverson BIRTHPLACE: Denmark.

14. MOTHER'S MAIDEN NAME: Christine Nelson BIRTHPLACE: Denmark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I 3 2

16. SOCIAL SECURITY NO.: 517 05 6247

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: John D. Iverson VA HOSPITAL RECORDS, BOISE, IDAHO.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cystic degeneration of cerebrum, multiple — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic thromboses, multiple.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart disease with myocardial infarction. — 1 month

334X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES XX NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-18, 19 67, to 10-19, 19 67, and that death occurred at 11:47 PM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): M. G. STROMBERG, M.D. 597

23b. ADDRESS: VA CENTER, BOISE, IDAHO.

23c. DATE SIGNED: 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/23/67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 11-1-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: G. W. Waters

LICENSE NO.: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 8 _ 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4262
Local Reg. No. 613
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 14 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 519 ½ South 13th Street

3. NAME OF DECEASED (Type or Print): a. (First) Richard — b. (Middle) 300 — c. (Last) Vivian

4. DATE OF DEATH: October 20, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: January 16, 1898

9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor 06

10b. KIND OF BUSINESS OR INDUSTRY: Laboring

11. BIRTHPLACE (State or foreign country): Silver City, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry Vivian — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Annie Daise — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

16. SOCIAL SECURITY NO.: 519-14-0360

17. INFORMANT'S OWN SIGNATURE: Wesley Records — ADDRESS: 1205 W. Bannock, Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 203X Multiple myeloma — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11/16, 19 65, *to* 10/20 19 67, *that I last saw the deceased alive on* 10/19/67 19___, *and that death occurred at* 4 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 054 (Degree or title): M.D.

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 1967 October 23,

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-10-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature]

LICENSE NO.: E-483

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4263
Local Reg. No. 585
Reg. Dist. No. 370

RECEIVED OCT 26 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 19 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: ADA 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1431 COLORADO AVE.

3. NAME OF DECEASED (Type or Print)
a. (First): THOMAS
b. (Middle): D.
c. (Last): MAJOR

4. DATE OF DEATH (Month) (Day) (Year): Oct. 20, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 22, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steamfitter 21
10b. KIND OF BUSINESS OR INDUSTRY: Plumbing &Pipe Fitting
11. BIRTHPLACE (State or foreign country): Longriggend, Scotland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Major — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Mary Murphy — BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 529-03-2579
17. INFORMANT'S OWN SIGNATURE: X Richard L Major — ADDRESS: Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Ortuorchiosis progressive — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/1, 1966, *to* 10/, 1967, *that I last saw the deceased alive on* 10/, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 318 (Degree or title)
23b. ADDRESS: 401 N. Orchard Boise Idaho
23c. DATE SIGNED: 10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/23/67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 10-26-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters [signature]
LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cloverdale Funeral Home 375-2212

OCT 2 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4264
Local Reg. No. 574
Reg. Dist. No. 370

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY in this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Nurs. Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2715 Lemhi St.

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) Adella 337 c. (Last) Stevens

4. DATE OF DEATH: (Month) Oct. (Day) 20, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Feb. 26, 1894

9. AGE (In years last birthday): 73 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Steele City, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward E. Waitley BIRTHPLACE: Mt. Vernon, Ohio

14. MOTHER'S MAIDEN NAME: Elsie Ann Ross BIRTHPLACE: Ft. Wayne, Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Mrs. Wretha Duret ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 260X CVA — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis
DUE TO (c) Diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — , 19 67, *to* 10/20, 19 67, *that I last saw the deceased alive on* 10/19, 19 67, *and that death occurred at* — m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 054 (Degree or title) M.D.
23b. ADDRESS: [illegible] Idaho
23c. DATE SIGNED: 10/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/21/67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-23-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature] LICENSE NO. E-466
FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 25 1973

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 14 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4265
Local Reg. No. 575
Reg. Dist. No. 370

RECEIVED
Bureau of Vital Statistics
STATE OF IDAHO

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 36-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 — OCT 25 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1216 North 19th.

3. NAME OF DECEASED (Type or Print): a. (First) Carl b. (Middle) Edwin c. (Last) Cluster

4. DATE OF DEATH: (Month) Oct. (Day) 21, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 20, 1883

9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cluster Tree Service

10b. KIND OF BUSINESS OR INDUSTRY: 21 Trees

11. BIRTHPLACE (State or foreign country): Pleasanton, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel Cluster — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Blanch McNeal — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: 519-01-4489

17. INFORMANT'S OWN SIGNATURE: Juanita Hawkins — ADDRESS: Boise

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9037

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Fx hip / Rt. — INTERVAL BETWEEN ONSET AND DEATH: 16 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Arteriosclerotic heart dis — 16 days

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: 10/7/67

19b. MAJOR FINDINGS OF OPERATION: Fx hip Right

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Nursing Home 13

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Boise Ada Ida

21d. TIME OF INJURY (Month) 10 (Day) 4 (Year) 67 (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Fell —

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS

23c. DATE SIGNED: 10/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-24-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-24-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson [signature] — LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 10 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4266
Local Reg. No. 581
Reg. Dist. No. 370

BIRTH NO.

OCT 25 1967

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 412 South Third

3. NAME OF DECEASED (Type or Print): a. (First) MINNIS b. (Middle) RICHARD 003 c. (Last) SHELTON

4. DATE OF DEATH (Month) (Day) (Year): October 21, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Oct. 28, 1887

9. AGE (In years last birthday): 79 — If under 1 year: Months / Days — If under 1 day: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired service-man

10b. KIND OF BUSINESS OR INDUSTRY: bus company

11. BIRTHPLACE (State or foreign country): Barry, Pike County, Ill.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Shelton — BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Martha Pryor — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO. 518-07-7579

17. INFORMANT'S OWN SIGNATURE: Clarence F. Shelton — ADDRESS: 1423 Hays Boise, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic bronchitis + emphysema — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease — 5 yrs +

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Spring, 1967, to Oct 21, 1967, that I last saw the deceased alive on Oct 21, 1967, and that death occurred at 8:15p m., from the causes and on the date stated above.

23a. SIGNATURE: C. R. Blackburn (Degree or title) MD

23b. ADDRESS: 800 La Cassia Way

23c. DATE SIGNED: 24 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Oct. 25 '67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 10-25-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Fred E. Walker — LICENSE NO. E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 4 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death ~~occurred for less than one year~~, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Smithson
Eastman Bldg

RECEIVED
NOV 2 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4267
Local Reg. No. 598
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 32-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4414 Irving St.

3. NAME OF DECEASED (Type or Print)
a. (First): CLYDE
b. (Middle): L.
c. (Last): NASH

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 16, 1888
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Fairbury, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John M. Nash — BIRTHPLACE: Michigan
14. MOTHER'S MAIDEN NAME: Abbie Mason — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-28-6978
17. INFORMANT'S OWN SIGNATURE: X Lila Nash — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis c̄ — INTERVAL BETWEEN ONSET AND DEATH: 3 Wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial decompensation — 3 Wks
DUE TO (c) Arteriosclerosis General — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ulcer esophageal — 6 Yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-16, 1961, *to* Oct. 21, 1967, *that I last saw the deceased alive on* 10-21, 1967, *and that death occurred at* 4:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl B. Smithson M.D. 484
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 24, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county): Boise — (State): Idaho

DATE REC'D BY LOCAL REG.: 10-31-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters — LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4268
Local Reg. No. 573
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED OCT 23 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. #1

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Titus
c. (Last): Longstreet

4. DATE OF DEATH: (Month) Oct. (Day) 21, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 25, 1922

9. AGE (In years last birthday): 45
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gen. Contractor 21

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Hillsboro, Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Calvin Longstreet
BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Allie Smith
BIRTHPLACE: Howell Co., Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W. 2 4

16. SOCIAL SECURITY NO.: 545-28-7149

17. INFORMANT'S OWN SIGNATURE: Mrs James Longstreet
ADDRESS:

201X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hodgkins Disease
INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 13 Oct, 19 67, *to* 19 Oct, 19 67, *that I last saw the deceased alive on* 21 Oct, 19 67, *and that death occurred at* 2:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Alfred M. Stone 504 (Degree or title) I
23b. ADDRESS: St Lukes Hosp Boise
23c. DATE SIGNED: 23 Oct 67

24a. BURIAL / CREMATION / REMOVAL (Specify): Removal 3
24b. DATE: 10/23/67
24c. NAME OF CEMETERY OR CREMATORY: Lodi Cemetery
24d. LOCATION (City, town, or county) (State): Lodi, California

DATE REC'D BY LOCAL REG.: 10-23-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. E. Alden
LICENSE NO.: 299

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McBratney-Alden-Waggoner

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 6 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4269
Local Reg. No. 379
Reg. Dist. No. 370

BIRTH NO.

RECEIVED OCT 26 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 01 2-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 5 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1004 O'Farrell

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Fred	L.	King	Oct.	21	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Jan. 15, 1889	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Navy Officer 05	Military	New York City, N.Y.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John King	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW I 3	552-36-8769	Florence King	1004 O'Farrell Boise, Idaho

331X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis — 10 yrs ±
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Anoxia, Esophageal Stricture

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 1960, *to* 10-21, 1967, *that I last saw the deceased alive on* 10-21, 1967, *and that death occurred at* 2:46 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James L. Koopingarm MD	104 N Latah Boise Idaho	10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 23, 1967	Morris Hill Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-25-67	Myrtle Palmer	J. Richard Reed	E-440

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 26 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 2 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 31 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4270
Local Reg. No. 588
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): Route # 6

3. NAME OF DECEASED (Type or Print)
a. (First): Hertha Louise
b. (Middle): Matilda
c. (Last): Kirchner

4. DATE OF DEATH (Month) (Day) (Year): October 22, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: January 1, 1910
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Shawano Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Krueger — BIRTHPLACE: Mayvellie, Wisc.
14. MOTHER'S MAIDEN NAME: Minnie Melcher — BIRTHPLACE: Shawano, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 398 05 5218
17. INFORMANT'S OWN SIGNATURE: Alfred Kirchner — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer lung with 1621

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): met to brain +
DUE TO (c): liver

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: Sept 1967
19b. MAJOR FINDINGS OF OPERATION: Increase intracranial pressure
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 30, 1967, *to* Oct 22, 1967, *that I last saw the deceased alive on* Oct 22, 1967 *and that death occurred at* 10:30A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 704 A H Lumpendall
23b. ADDRESS:
23c. DATE SIGNED: 10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn Cemetery
24d. LOCATION (City, town, or county) (State): Ada County Idaho

DATE REC'D BY LOCAL REG.: 10-30-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Richard W. Mesenbrink — LICENSE NO. E-487

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Alsip Funeral Chapel

DUTIES:-

OCT 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Rec'd Overland

Certificate of Death

STATE OF IDAHO

State File No. 4271
Local Reg. No. 591
Reg. Dist. No. 370

BIRTH NO. RECEIVED

1. PLACE OF DEATH
a. COUNTY Ada 011 NOV 2 1967 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho 260 b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rigby
d. STREET ADDRESS (If rural, give location) 151 South 2nd West

3. NAME OF DECEASED (Type or Print) a. (First) ANN b. (Middle) WALTERS c. (Last) NIELSEN

4. DATE OF DEATH (Month) (Day) (Year) Oct. 23, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 15, 1894
9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY House work
11. BIRTHPLACE (State or foreign country) Wellsville, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Leigh Walters BIRTHPLACE Llanelly, Wales
14. MOTHER'S MAIDEN NAME Mary Archibal Kerr BIRTHPLACE Possum Hollow, Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-7600-B
17. INFORMANT'S OWN SIGNATURE X [signature] ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 5 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardiovasc dis.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes - mild.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-19, 1967, *to* 10-23 1967, *that I last saw the deceased alive on* 10-23, 1967 *and that death occurred at* 9:55 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE 447 F.K. Root J. MD (Degree or title)
23b. ADDRESS 6003 Overland, Boise
23c. DATE SIGNED 10-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Oct. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY Rigby Cemetery
24d. LOCATION (City, town, or county) Rigby, (State) Idaho

DATE REC'D BY LOCAL REG. 10-31-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Conway Grant
LICENSE NO. E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY BOISE, IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 1967

DEC 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 1 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4272
Local Reg. No. 167
Reg. Dist. No. 371

RECEIVED NOV 3 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 1-18
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 18 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 32oo North 36th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3200 North 36th Street

3. NAME OF DECEASED (Type or Print)
a. (First) STANLEY
b. (Middle) W. 000
c. (Last) TUCKER

4. DATE OF DEATH (Month) (Day) (Year) October 24, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Oct. 14, 1885
9. AGE (In years last birthday) 82 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer 04
10b. KIND OF BUSINESS OR INDUSTRY nursery
11. BIRTHPLACE (State or foreign country) Punxsutawney, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME A. H. Tucker
BIRTHPLACE Pennsylvania
14. MOTHER'S MAIDEN NAME Anna Windslow
BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. 519-40-2438
17. INFORMANT'S OWN SIGNATURE Mrs Elda Tucker
ADDRESS 3200 N.36th Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1959, *to* Oct. 24, 1967, *that I last saw the deceased alive on* Oct. 22, 1967, *and that death occurred at* 7:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE C. C. Johnson 261 (Degree or title) MD
23b. ADDRESS 425 W. Bannock, Boise, Idaho, 83702
23c. DATE SIGNED 10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct.26,1967
24c. NAME OF CEMETERY OR CREMATORY Terrace Lawn
24d. LOCATION (City, town, or county) Meridian (State) Idaho

DATE REC'D BY LOCAL REG. 11-1-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Howell D. Demaray
LICENSE NO. E-509

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4273
Local Reg. No. 585
Reg. Dist. No. 370

Certificate of Death

RECEIVED
OCT 31 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 1-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 4 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4014 State

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Gerald
c. (Last): Turner

4. DATE OF DEATH (Month) (Day) (Year): Oct. 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 29, 1880
9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant 22
10b. KIND OF BUSINESS OR INDUSTRY: Turners Inn.
11. BIRTHPLACE (State or foreign country): County Rosecommon, Ireland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Turner
BIRTHPLACE: Ireland
14. MOTHER'S MAIDEN NAME: Ann Dalton
BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Robert L. Turner
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4918

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Bronchopneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/30, 1964, *to* 10/21, 1967, *that I last saw the deceased alive on* 10/21, 1967, *and that death occurred at* 5:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Clohessy, M.D. 095
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 10/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 28, 67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 10-27-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson
LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 10 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 13 2005

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4274
Local Reg. No. 168
Reg. Dist. No. 371

RECEIVED NOV 3 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (in this place): 29 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): Star Route.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Arthur	E	SPIKER.	10	26	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married.	8-6-95	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Woodsman. 30
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Wisconsin.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Rudolph A Spiker. BIRTHPLACE: Wisc.
14. MOTHER'S MAIDEN NAME: Millie Pake. BIRTHPLACE: Wisc
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 519105210
17. INFORMANT'S OWN SIGNATURE AND ADDRESS: John E Spiker VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Respiratory acidosis	36 hrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Pulmonary fibrosis	4 yrs
DUE TO (c)	Chronic Lipoid pneumonia	?
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Arteriosclerotic heart disease	3 yrs

4918

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

~~I hereby certify that I~~ attended the deceased from 9-27 1967, to 10-26, 1967 ~~last seen alive on~~, and that death occurred at 11PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
GLENN Q VOYLES, M.D.	VA Center, Boise, Idaho.	10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	10-27-67		New Bedford, North Dakota

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-1-67	Myrtle Palmer		E-410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4275
Local Reg. No. 586
Reg. Dist. No. 370

RECEIVED OCT 31 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2514 Heights Drive

3. NAME OF DECEASED (Type or Print): a. (First) June b. (Middle) Arlene c. (Last) Davies

4. DATE OF DEATH (Month) (Day) (Year): Oct. 26, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 8-3-1922

9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office Worker 08

10b. KIND OF BUSINESS OR INDUSTRY: State of Idaho

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm. O. Storey — BIRTHPLACE: Owyhee County Idaho

14. MOTHER'S MAIDEN NAME: Bessie Denten — BIRTHPLACE: Mtn. Home, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: 519-14-2696

17. INFORMANT'S OWN SIGNATURE: E. W. Davies — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 10 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Paralytic ileus, post operative 8 days

19a. DATE OF OPERATION: 10/12/67

19b. MAJOR FINDINGS OF OPERATION: Fibroid uterus; Ovarian cysts, right and left ovaries.

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/11, 1967, *to* 10/26, 1967, *that I last saw the deceased alive on* 10/26, 1967, *and that death occurred at* 11:55a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert L. Smith, M.D. (Degree or title)

23b. ADDRESS: 312 W Idaho St. Boise, Idaho

23c. DATE SIGNED: 10/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-28-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 10-27-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 3 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 6 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 2 5 1976

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4276
Local Reg. No. 778
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): Few Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route #1 Hwy 44 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): 327 SW Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	CLAY	KING	October 26,1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married 3	October 21,1905	62	- / -	- / -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 010	Construction	Kentucky	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mike King	Kentucky	Margaret Parker	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- -	721-14-0199	Helene G. King	Seattle, Wash.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Crushed Chest & Broken Neck. — INTERVAL BETWEEN ONSET AND DEATH: Inst;

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: working with large cement mixer was up on it, tripped leaver, Hopper slammed up crushed him against frame.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident / 20	13	000

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ / NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
IO 26 67 6P m. 2		working on large cement mixer. crushed between Hopper & frame.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 6 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
0583	Coroner	3720 Meadow Drive, Boise,	IO-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	Oct.30,1967	Park View	New Plymouth Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-2-67	Myrtle Palmer	Jerry K. Lawson Jerry K Lawson	E-522

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 3 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4277
Local Reg. No. 596
Reg. Dist. No. 370

BIRTH NO. 3-09

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Malheur 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ontario
d. STREET ADDRESS (If rural, give location): 1173 S. W. 3 Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	F.	Beatie	Oct. 26 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Feb. 6, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Contractor-Engineering	U. S. Eng.	Pendleton, Oregon	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert B. Beatie	Carus, Oregon	Carrie Belle Myers	Oregon City, Ore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3		Mrs. Charles F. Beatie	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Acute myelocytic leukemia	1 mo.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 17 Oct, 1967, *to* 26 Oct, 1967, *that I last saw the deceased alive on* 26 Oct, 1967, *and that death occurred at* 11 55p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J Hugh Atchley 014	MD	401 Idaho St Boise Idaho	30 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-30-1967	Evergreen Cemetery	Ontario, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-1-67	Myrtle Palmer	Lowell Summers	E-509

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 6 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 1 1968

MAR 17 1976

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4278
Local Reg. No. 608
Reg. Dist. No. 370

Certificate of Death

RECEIVED
NOV 8 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 380
b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): Route #2 2 Mi W. New Plymouth

3. NAME OF DECEASED (Type or Print)
a. (First): MERRITT
b. (Middle): CLAIR
c. (Last): REMINGTON

4. DATE OF DEATH (Month) (Day) (Year): October 26, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 7, 1904
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months – Days – IF UNDER 24 HRS.: Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Merritt Clark Remington — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Cora Belle Fairy — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): – –
16. SOCIAL SECURITY NO.: 508-07-5311
17. INFORMANT'S OWN SIGNATURE: Mrs Clair Remington — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4341

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Chronic Congestive
DUE TO (c): Heart failure — 3 mos

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 23, 1967, *to* Oct 26, 1967, *that I last saw the deceased alive on* Oct 26, 1967, *and that death occurred at* 3:22 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W Nowinski Jr. 393
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial 3
24b. DATE: Oct. 31, 1967
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: 11-6-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shaffer Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4279
Local Reg. No. 594
Reg. Dist. No. 370

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO. 2-005

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 5 months

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Nursing Home
d. STREET ADDRESS (If rural, give location): 1003 Vermont Street

3. NAME OF DECEASED (Type or Print): a. (First) FELIX b. (Middle) J92 S. c. (Last) NEDROW

4. DATE OF DEATH: (Month) (Day) (Year): October 26, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: July 26, 1890

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): mechanic 21

10b. KIND OF BUSINESS OR INDUSTRY: automobile

11. BIRTHPLACE (State or foreign country): Falls City, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: S. W. Nedrow
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Emma Kitch
BIRTHPLACE: Falls City, Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 519-34-5345

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Myrtle S. Nedrow, 1003 Vermont, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral and Coronary Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Severe degenerative arthritis; Chronic cystitis; Deep decubitus ulcers.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Pancreatitis and cholelithiasis.

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan. 31, 19 67, *to* October 26, 19 67, *that I last saw the deceased alive on* Oct. 26, 1967, *and that death occurred at* 4:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Johnson M.D.

23b. ADDRESS: 425 W. Bannock, Boise, Idaho, 83702

23c. DATE SIGNED: 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 30, 1967

NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 11-1-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Fred E. Walker

LICENSE NO.: E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 1 - 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4280
Local Reg. No. 598
Reg. Dist. No. 370

Certificate of Death

RECEIVED NOV 3 1967 Bureau of Vital Stat.

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 wk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print)
a. (First): Wesley
b. (Middle): William
c. (Last): Kanoff

4. DATE OF DEATH (Month) (Day) (Year): Oct. 27, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 5, 1879
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer Retired
10b. KIND OF BUSINESS OR INDUSTRY: 04
11. BIRTHPLACE (State or foreign country): Yate Center, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob J. Kanoff — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Catherine Bell — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-58-9540-J1
17. INFORMANT'S OWN SIGNATURE: Blanche Kanoff — ADDRESS: Rt. Meridian

18. CAUSE OF DEATH 2001
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Age & Debility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma Prostate — 1 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-30, 1967, *to* Oct 27, 1967, *that I last saw the deceased alive on* Oct 27, 1967, *and that death occurred at* 3:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE 393 (Degree or title): Fran Whowrus Jr
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-30-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 11-2-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jerrod
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4281
Local Reg. No. 169
Reg. Dist. No. 371

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

NOV 3 1967 2-02

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (in this place): 48 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Sunset Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada 011

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 3115 Sycamore Drive

3. NAME OF DECEASED (Type or Print)

a. (First): Herbert

b. (Middle): E. 235

c. (Last): Stewart

4. DATE OF DEATH (Month) (Day) (Year): Oct. 27 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Nov. 2, 1883

9. AGE (In years last birthday): 83

IF UNDER 1 YEAR: Months | Days

IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Clarksville, Arkansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Benjamin Stewart

BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Harmon ------

BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-36-0948

17. INFORMANT'S OWN SIGNATURE: x Mrs. Marvin L. Robertson

ADDRESS: Boise, Ida

493X

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): —

DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1960, *to* 10-27, 1967, *that I last saw the deceased alive on* 10-18, 1967, *and that death occurred at* 5:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: W. D. Forney 173 (Degree or title): MD 1

23b. ADDRESS: 425 Bannock St Boise

23c. DATE SIGNED: 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 30/67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 11-1-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature] McMartney

LICENSE NO.: E 410

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendent. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4282
Local Reg. No. 599
Reg. Dist. No. 370

BIRTH NO.

NOV 3 1967

Bureau of Vital

1. PLACE OF DEATH
a. COUNTY Ada 001 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Ada 001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) Restful Manor Nursing HOme

3. NAME OF DECEASED (Type or Print) a. (First) Jessie b. (Middle) Jane c. (Last) Myers

4. DATE OF DEATH (Month) (Day) (Year) Oct. 27. 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 10, 1882
9. AGE (In years last birthday) 84 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home 01
10b. KIND OF BUSINESS OR INDUSTRY homemaking
11. BIRTHPLACE (State or foreign country) Cheboygan, Michigan
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Maynard S. Corlett BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Nellie V. Beaudoin BIRTHPLACE Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mrs. C. M. Corlett ADDRESS Boise, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2041 Myelogenous Leukemia — INTERVAL BETWEEN ONSET AND DEATH: 2 Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Renal Failure — 2 wks
DUE TO (c) Multiple areas of bleeding,

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Stomach — Uterus, bowel — 5 wks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-11-, 1966, *to* Oct 27, 1967, *that I last saw the deceased alive on* Oct 26, 1967, *and that death occurred at* 3:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE W. D. Springer MD (Degree or title) 4/91
23b. ADDRESS 220 N 15th Boise Idaho
23c. DATE SIGNED 10-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Memorial Gardens
24d. LOCATION (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. 11-2-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Richard W. Messenbrink
LICENSE NO. E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4283
Local Reg. No. 166
Reg. Dist. No. 371

Certificate of Death

RECEIVED STATE OF IDAHO

NOV 1 1967 1-01

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF [illegible] (in this place): 10 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Sunset Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 715 N. 13th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Ernest
b. (Middle): B. 235
c. (Last): Feltner

4. DATE OF DEATH (Month) (Day) (Year): Oct. 28 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 9, 1876
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stone-cutter - Feltner Memorials
10b. KIND OF BUSINESS OR INDUSTRY: Monuments.
11. BIRTHPLACE (State or foreign country): Lion County, Kentucky
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Sam Feltner 21
BIRTHPLACE: Tennessee
14. MOTHER'S MAIDEN NAME: Sally May Travis
BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-07-8150
17. INFORMANT'S OWN SIGNATURE: Paul E. Feltner
ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis + Senility — INTERVAL BETWEEN ONSET AND DEATH: 20 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Arteriosclerotic heart, cerebral + Kidney

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1966, *to* Oct 28, 1967, *that I last saw the deceased alive on* Oct 2, 1967, *and that death occurred at* 4 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R M Chalaupka 088 MD
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 10/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 30/67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 11-1-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Powell [illegible]
LICENSE NO.: E-509

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 1 - 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 13 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 11 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4284
Local Reg. No. 597
Reg. Dist. No. 370

RECEIVED NOV 3 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 5 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1009 N. 12th Street

3. NAME OF DECEASED (Type or Print): a. (First) Blanche b. (Middle) c. (Last) Jones

4. DATE OF DEATH: (Month) Oct. (Day) 28 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Mar. 1, 1885

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Minneapolis, Minnesota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: A. M. Slatery — BIRTHPLACE: Nova Scotia

14. MOTHER'S MAIDEN NAME: Eliza Amelia Atwater — BIRTHPLACE: Nova Scotia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 519-30-5089

17. INFORMANT'S OWN SIGNATURE: X Margie D. Jones — ADDRESS: 1009 N. 12th Boise, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Lymphocytic Leukemia	10 wks.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Left hemiplegia	7 Months
DUE TO (c)	Arteriosclerosis	5 yrs.
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Herpes Zoster	8 Months

2040

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1967, *to* 10-28, 1967, *that I last saw the deceased alive on* 10-27-1967, *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. D. Spangler MD 4/91

23b. ADDRESS: 220 N 1st Burley Ida

23c. DATE SIGNED: 10-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 31/67

24c. NAME OF CEMETERY OR CREMATORY: Bruneau Cemetery

24d. LOCATION (City, town, or county) (State): Bruneau Idaho

DATE REC'D BY LOCAL REG.: 11-1-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Lowell Summers

LICENSE NO.: E 509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4285
Local Reg. No. 171
Reg. Dist. No. 371

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: ADA. 011 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
c. LENGTH OF STAY (in this place): 16 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO. b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 2910 Clark St

3. NAME OF DECEASED (Type or Print): a. (First) George b. (Middle) V c. (Last) STOUGHTON

4. DATE OF DEATH: (Month) 10 (Day) 28 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married. 3

8. DATE OF BIRTH: 7-5-06

9. AGE (In years last birthday): 61. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Electrical Eng. 21

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Whitefield, N. H.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James E Stoughton. BIRTHPLACE: Canada,

14. MOTHER'S MAIDEN NAME: Lotti e Aldrich. BIRTHPLACE: N.H.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 2 4

16. SOCIAL SECURITY NO.: 001 07 55 58

17. INFORMANT'S OWN SIGNATURE: John E Stark ADDRESS: VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinoma, metastatic, site of origin unknown. — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease. — 11 yrs.

1992

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-12, 19 67, to 10-28, 19 67, that I last saw the deceased alive on [illegible] and that death occurred at 8:55 AM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): M. G. STROMBERG, M.D. 597

23b. ADDRESS: VA Center, Boise, Idaho.

23c. DATE SIGNED: 10-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/30/67

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-6-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: C. E. Alden LICENSE NO.: 299

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4286
Local Reg. No. 602
Reg. Dist. No. 370

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3025 Warm Springs Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Rachael b. (Middle) C. c. (Last) Cary

4. DATE OF DEATH: (Month) Oct. (Day) 28, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 9, 1917

9. AGE (In years last birthday): 50
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Secretary 19

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boston, Mass.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Curtis W. Chenoweth
BIRTHPLACE: W.Va.

14. MOTHER'S MAIDEN NAME: Jessie Rider
BIRTHPLACE: W. Va.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 543-28-1481

17. INFORMANT'S OWN SIGNATURE: Dr B W Baum
ADDRESS: Box 492 McCall Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/12, 19 67, *to* 10/28, 19 67, *that I last saw the deceased alive on* 10/28, 19 67, *and that death occurred at* 5:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. Chenoweth 095, M.D. (Degree or title)
23b. ADDRESS: Boise, Ida
23c. DATE SIGNED: 10/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/1/67
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-2-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. E. Alden
LICENSE NO.: 299

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4287
Local Reg. No. 587
Reg. Dist. No. 370

Certificate of Death

RECEIVED OCT 31 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 235 South 10th.

3. NAME OF DECEASED (Type or Print)
a. (First): Althea
b. (Middle): -----
c. (Last): Domy

4. DATE OF DEATH (Month) (Day) (Year): Oct. 28, 1967

5. SEX: Female
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 7-29-1939
9. AGE (In years last birthday): 28 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Owyhee, Nevada
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Neuman Jones — BIRTHPLACE: Nevada
14. MOTHER'S MAIDEN NAME: Letha Sue — BIRTHPLACE: U.S.A.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Gus Garity — ADDRESS: Nevada

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Cirrhosis of liver — 1 month

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: Oct 13, 67
19b. MAJOR FINDINGS OF OPERATION: Acute Hepatitis and Cirrhosis
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 4, 1967, *to* Oct 28, 1967, *that I last saw the deceased alive on* Oct 27, 1968, *and that death occurred at* 3:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 333 (Degree or title)
23b. ADDRESS: 808 La Cassia Dr Boise
23c. DATE SIGNED: Oct 30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-31-67
24c. NAME OF CEMETERY OR CREMATORY: Owyhee Cemetery
24d. LOCATION (City, town, or county) (State): Owyhee, Nevada

DATE REC'D BY LOCAL REG.: 10-30-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 2 0 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 2 1 2008

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 1 2 1978

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4288
Local Reg. No. 392
Reg. Dist. No. 370

Certificate of Death

RECEIVED STATE OF IDAHO

NOV 1 1967

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2900 Hayden Way 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 070 Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bellevue
d. STREET ADDRESS (If rural, give location): R.F.D.

3. NAME OF DECEASED (Type or Print): a. (First) Chester b. (Middle) A. c. (Last) Porter

4. DATE OF DEATH (Month) (Day) (Year): Oct. 28, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 11, 1905

9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Gate, Oklahoma

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew Porter
BIRTHPLACE: Oklahoma

14. MOTHER'S MAIDEN NAME: Nellie Cunningham
BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-26-4975

17. INFORMANT'S OWN SIGNATURE: Emmie M Porter
ADDRESS: Bellevue

4201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis
INTERVAL BETWEEN ONSET AND DEATH: Few Min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Become ill, & Collapsed in bath room.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Did Not See Alive m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 330A m., from the causes and on the date stated above.

23a. SIGNATURE: 583 Harris (Degree or title) Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise
23c. DATE SIGNED: 11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/31/67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-1-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. E. Alden
LICENSE NO.: 299
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4289
Local Reg. No. 372
Reg. Dist. No. 370

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 6515 Fairview Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6515 Fairview Avenue

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) 000 c. (Last) Phillips

4. DATE OF DEATH: (Month) Oct. (Day) 29, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug. 7, 1886

9. AGE (In years last birthday): 81 (IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Forest Ranger 08

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): Heber City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred T. Phillips BIRTHPLACE: Great Britain

14. MOTHER'S MAIDEN NAME: Martha Jane Baird BIRTHPLACE: Utah Heber City,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-32-0306-A

17. INFORMANT'S OWN SIGNATURE: Fred L. Phillips ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary artery Heart disease

DUE TO (c) Coronary atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec ?, 1966, *to* Oct 29, 1967, *that I last saw the deceased alive on* 10-27, 1967, *and that death occurred at* ? A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. E. Carpenter M.D. 094

23b. ADDRESS: 311 - Idaho St Boise Ida

23c. DATE SIGNED: 11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal B

24b. DATE: 11/1/67

24c. NAME OF CEMETERY OR CREMATORY: Salmon Cemetery

24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: 11-1-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: L. E. Alden LICENSE NO.: 299

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 1 1967

NOV 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4290.
Local Reg. No. 603
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 6 1967 2-03

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): ten weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route 2, Ustick Rd.

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): FREDRICK
c. (Last): BRIGGS

4. DATE OF DEATH (Month) 10 (Day) 29 (Year) 67

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: 4 16 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Emmetsburg, Iowa
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME — BIRTHPLACE: William Wesley Briggs, Litchfield, Illinois
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Emily A. Jones, Raymond, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-09-4370A
17. INFORMANT'S OWN SIGNATURE — ADDRESS: + Mrs John L. E. Jurrola

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anuria - Pylonephritis

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic Gangrene
DUE TO (c) Diabetes

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* BK Amp rt - Left hernia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 10-4-
19b. MAJOR FINDINGS OF OPERATION: BK amp - Gangrene - arteriosclerotic Ing Hernia - Sliding - Dr Sowers
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1, 1967, *to* 10-29, 1967, *that I last saw the deceased alive on* 10-29, 1967, *and that death occurred at* 8:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. L. Dames 125 MD
23b. ADDRESS: 1015 708 Boise
23c. DATE SIGNED: 10/31

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: October 31, 1967
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-2-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Jerry K. Lawson
LICENSE NO.: 522

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Nov. 8, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4291
Local Reg. No. 601
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01 — 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6901 Ashland

3. NAME OF DECEASED (Type or Print): a. (First) James — b. (Middle) Nicholas — c. (Last) Werry

4. DATE OF DEATH: (Month) October (Day) 30, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept 21, 1921
9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher-State Dept Education 12
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Bellevue, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Fred A. Werry — BIRTHPLACE: Bellevue, Idaho
14. MOTHER'S MAIDEN NAME: Edith Jones — BIRTHPLACE: Hailey, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 518-14-7036
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Jean L. Werry, 6901 Ashland, Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pan hypopituitarism

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-26, 19 67, *to* 10-30, 19 67, *that I last saw the deceased alive on* 10-30-67, 19 ____, *and that death occurred at* 1:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 095 C. E. Clohessy, M.D.
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-1-67
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: 11-2-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Fred E. Walker
LICENSE NO.: E-583

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Summers Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho
County of Ada } ss.

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for James Nicholas Werry (Name on Original Certificate) who died (Was Born or Died) on Oct. 30, 1967 (Date of Event)
in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Idaho Driver's License (Bible Record, Insurance Policy, Etc.) prepared on September 21 (Give Date) 1966, are:

FACTS TO BE CORRECTED ("Name" "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 8	Sept. 2, 1920	Sept. 21, 1921
Item 9	47	46

Subscribed and sworn to before me this seventh day of November, 1967

Notary Public, residing at Boise, Idaho
My commission expires September 10, 1970
(Seal)

Signed (Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

1205 Bannock St., Boise, Idaho (Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Ada } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this seventh day of November, 1967

Notary Public, residing at Boise, Idaho
My commission expires September 10, 1970
(Seal)

Signed (Signature of Any Credible Person)

1205 Bannock St., Boise, Idaho (Street Address, City, State)

FORM DH 60-155 3 C.C. gd - Rec # 23586.

NOTARY
PUBLIC
STATE OF IDAHO

NOTARY
PUBLIC
STATE OF IDAHO

State File No. .....
Local Reg. No. 601
Reg. Dist. No. 370

Certificate of Death

RECEIVED
NOV 2 1967
Bureau of V.

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 6901 Ashland

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): NICHOLAS
c. (Last): WERRY

4. DATE OF DEATH (Month) (Day) (Year): Oct. 30, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 2, 1920
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher- State
10b. KIND OF BUSINESS OR INDUSTRY: Dep't Education
11. BIRTHPLACE (State or foreign country): Bellevue, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Fred A. Werry, Bellevue, Idaho
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Edith Jones, Hailey, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II
16. SOCIAL SECURITY NO.: 518-14-7036
17. INFORMANT'S OWN SIGNATURE — ADDRESS: 6901 Ashland, Boise, Idaho
X Jean L. Werry

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerotic heart disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Pan hypopituitarism —

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/26, 1967, *to* 10/30, 1967, *that I last saw the deceased alive on* 10/30, 1967, *and that death occurred at* 1:00 AM, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature], M.D.
23b. ADDRESS: Boise, Ida.
23c. DATE SIGNED: 11/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-1-67
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: 11-2-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-583
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 2 - 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 15 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 14 1976

NOV 23 1990

JUN 17 1996

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4292
Local Reg. No. 600
Reg. Dist. No. 370

RECEIVED NOV 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2721 Esquire Drive

3. NAME OF DECEASED (Type or Print): a. (First) J. b. (Middle) Florence 332 c. (Last) Arduser

4. DATE OF DEATH: (Month) Oct. (Day) 30, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 29, 1884
9. AGE (In years last birthday): 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Manchester, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Marschall BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Unk. BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 482-05-4725
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: 2724 Adams Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generlized arteriosclerosis — 10 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fx left hip — 5 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 June, 1967, *to* 30 Oct, 1967, *that I last saw the deceased alive on* 14 Oct, 1967, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Clayton C. Mauger 370 (Degree or title) M.D.
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 2 Nov 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 11/2/67
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Crematory
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-2-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature] LICENSE NO.: E-460
FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4293
Local Reg. No. 605
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2510 W. State

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	Michael	Stack	Oct. 31, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Jan. 1, 1893	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman 24	U.A.R.C.O.	Eureka, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Stack	Unknown	Mary Ann O'Connell	Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	----------	518-09-7650	Mrs. W. M. Stack	Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Myocardial Infarction	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Coronary artery Heart	
DUE TO (c)	disease	SUDDEN
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Cerebral Vascular Hemorrhage	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-31, 1966, *to* 10-31, 1967, *that I last saw the deceased alive on* 10-31, 19 67, *and that death occurred at* 2 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
John E Coffin M.D.	311 Idaho St Boise	11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-4-67	Morris Hill	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-3-67	Myrtle Palmer	Daniel G. Gibson	E-400

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Gibson Funeral Home

DUTIES:

NOV 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 8 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 28 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

APR 26 1968

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

NOV 6 1981

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

NOV 9 1981

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4294
Local Reg. No. 1774
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 1-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4004 Collister Drive 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4004 Collister Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NANCY	ELLEN	LOONEY	October 31, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	divorced	March 20, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Mitchell, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Eugene Looney — BIRTHPLACE: Tennessee
14. MOTHER'S MAIDEN NAME: Gertrude Shrum — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 518-54-0720
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Cambridge, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Paralysis Agitans — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chronic Cystitis

350X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1962, *to* Oct, 1967, *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at* 11:42 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. A. Johnson 261	MD1	Boise Ida	11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	11-2-67	Boise Mausoleum	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-6-67	Myrtle Palmer	J. Willard Reed	E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 14 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4295
Local Reg. No. 604
Reg. Dist. No. 370

Certificate of Death

67-8264 RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 6 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route 3, Victory Road

3. NAME OF DECEASED (Type or Print)
a. (First): DEBORAH
b. (Middle): KAY
c. (Last): WATKINS

4. DATE OF DEATH (Month) (Day) (Year): October 31, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant 1
8. DATE OF BIRTH: August 23, 1967
9. AGE (In years last birthday): -
IF UNDER 1 YEAR: Months 2 Days 8
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Bill H. Watkins
BIRTHPLACE: Harrison, Arkansas
14. MOTHER'S MAIDEN NAME: Mary Alice Alsop
BIRTHPLACE: New Plymouth, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: ---
17. INFORMANT'S OWN SIGNATURE: Bill Watkins
ADDRESS: Rt. 3, Victory Road, Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

491X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: malnoutrition — ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-30, 1967, *to* 10-31, 1967, *that I last saw the deceased alive on* 10-31, 1967, *and that death occurred at* 6:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Sgt Swinehart 519 in D1
23b. ADDRESS: 200 E Bannock St Boise
23c. DATE SIGNED: 11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Nov. 1, 1967
24c. NAME OF CEMETERY ~~OR CREMATORY~~: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise, Route 1, Idaho

DATE REC'D BY LOCAL REG.: 11-2-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: F. Richard Reed
LICENSE NO.: E-440

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4296
Local Reg. No. 179
Reg. Dist. No. 371

BIRTH NO.

RECEIVED NOV 10 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 ADA. 1-01
b. CITY OR TOWN Boise, Idaho.
LENGTH OF STAY (in this place) 207 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION Vet. Admin. Center 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho. b. COUNTY 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RT # 1. Caldwell, Idaho.
d. STREET ADDRESS (If rural, give location) RT # 1. Caldwell, Idaho.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Abraham	NMI	BARBERIS.	10	31	67.

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	12 7 95	71	10	24		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired School Bus Driver. 10b. KIND OF BUSINESS OR INDUSTRY Same
11. BIRTHPLACE (State or foreign country) Italy.
12. CITIZEN OF WHAT COUNTRY? U S A.

13. FATHER'S NAME Pete Barberis. BIRTHPLACE Italy
14. MOTHER'S MAIDEN NAME Judith Parchini. BIRTHPLACE Italy.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW I 3
16. SOCIAL SECURITY NO. 508 05 2251
17. INFORMANT'S OWN SIGNATURE John D. Stark ADDRESS VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1631

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic carcinoma left lung with metastatic spread to right lung. — INTERVAL BETWEEN ONSET AND DEATH: 2 Years 6 Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary emphysema — 10 Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I hereby certify that I attended the deceased from 4-7, 19 67, to 10-31, 19 67, [illegible] and that death occurred at 3:15PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. W. Laxson W. W. LAXSON, M.D. 597 /	VA Center, Boise, Idaho.	11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11/6/67	Canyon Hill	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-9-67	Myrtle Palmer	Jerry M. Flahiff	E393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. OCT 8 1985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4297
Local Reg. No. 18
Reg. Dist. No. 300

BIRTH NO.

OCT 17 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence, 109 Lucille Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Adams 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
d. STREET ADDRESS (If rural, give location): 109 Lucille Ave.

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES; b. (Middle) EUGENE 000; c. (Last) HAM

4. DATE OF DEATH: (Month) 10 (Day) 5 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: 2/16/1894

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 08

10b. KIND OF BUSINESS OR INDUSTRY: Forest Service

11. BIRTHPLACE (State or foreign country): Prescott, Washington

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Charles L. Ham
BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: Eunice Belle Barnett
BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W W I 3

16. SOCIAL SECURITY NO.: 42201

17. INFORMANT'S OWN SIGNATURE: Mrs. Hilda K. Ham
ADDRESS: Council, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased* dead *alive on* October 5 1967, *and that death occurred at* 11:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 154 (Degree or title): /

23b. ADDRESS: Council, Idaho

23c. DATE SIGNED: 10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/9/1967

24c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery

24d. LOCATION (City, town, or county) (State): Council Idaho

DATE REC'D BY LOCAL REG.: 10-10-67

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Marshall S. Dickerson Jr.

LICENSE NO.: E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 17 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 20 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 1 1980

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 4298
Local Reg. No. 19
Reg. Dist. No. 300

BIRTH NO.

RECEIVED STATE OF IDAHO

OCT 23 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Adams 020 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Council Hospital 017

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Adams 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Indian Valley
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print)
a. (First): GENEVA
b. (Middle): HELEN
c. (Last): BOEHM

4. DATE OF DEATH (Month) (Day) (Year): Oct. 14 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Nov.20,1924
9. AGE (In years last birthday): 42 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Indian Valley, Idaho
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Earl E. Byers — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: Nellie Murphy — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Larry L. Boehm — ADDRESS: Indian Valley, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Subdural Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Farm-market road 06
21c. (CITY, TOWN, OR TOWNSHIP): Indian Valley 13 — (COUNTY): Adams 020 — (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10 11 67 5:30pm 2
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2
21f. HOW DID INJURY OCCUR? Car accident

22. *I hereby certify that I attended the deceased from* 10-11, 19 67, *to* 10-14, 19 67, *that I last saw the deceased alive on* 10-14, 19 67, *and that death occurred at* 1:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 154 (Degree or title) 1
23b. ADDRESS: Council, Idaho
23c. DATE SIGNED: 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 10/18/67
24c. NAME OF CEMETERY OR CREMATORY: Indian Valley, Cemetery
24d. LOCATION (City, town, or county) (State): Indian Valley, Idaho

DATE REC'D BY LOCAL REG.: 10-18-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Marshall S. Dickerson Jr.
LICENSE NO.: E-464

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 17 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4299
Local Reg. No. 20
Reg. Dist. No. 300

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Adams 020 — c. LENGTH OF STAY (in this place) 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Council
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) South East Council 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 47 — b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 159 E. Comm.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARSHALL		DICKERSON	Oct. 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 13, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Mechanic 21	Weiser Cyclery	Weiser, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis M. Dickerson	Kansas	Anna Galloway	Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	1922-1928 6	519-10-6978	Marshall L Dickerson Jr.	Weiser, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 1:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold Whatley 597 Adams County Coroner 4	P.O. BOX 215 Council, Idaho	11-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. Burial 3	Oct. 28, 1967	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-7-67		T. Lee Thomason	E-388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 1 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 1 2 1995

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4500
Local Reg. No. 268
Reg. Dist. No. 510

RECEIVED

Certificate of Death

STATE OF IDAHO

OCT 12 1967

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 228 Taft

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	SARAH	LILLIAN	WILKER	October 1, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Dec. 31, 1888	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Paris, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fredric Wm. Hurst	Utah	Deseret Alvira Lindsay	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Charles Roland Wilker	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 Hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Hypertension — 4 Yrs.

DUE TO (c) Arteriosclerosis, general — 4 Yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* — , 196 , *to* 01- X , 1967 , *that I last saw the deceased alive on* 01- X , 1967 , *and that death occurred at* 1730 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.J.Sharp, M.D.	5th & Center, Pocatello, Idaho	10/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 4, 1967	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 11 1967			E418

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 20 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED.. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4301
Local Reg. No. 266
Reg. Dist. No. 510

RECEIVED
OCT 10 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 136 So. 8th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 136 So. 8th

3. NAME OF DECEASED (Type or Print)
a. (First): CLARENCE
b. (Middle): A.
c. (Last): GARRETT

4. DATE OF DEATH (Month) (Day) (Year): Oct. 2, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 21, 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pres. & Gen.Mgr. 26
10b. KIND OF BUSINESS OR INDUSTRY: Garrett Freightlines
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Samuel B. Garrett — BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Jeanette Garrett — BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-09-9901
17. INFORMANT'S OWN SIGNATURE: Dorothy E. Garrett — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arterio Sclerosis — 10 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1945, *to* 10-2-, 1967, *that I last saw the deceased alive on* 10-2, 1967, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. F. Overturf, D.O. 2 — 1588
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct.6-67
24c. NAME OF CEMETERY OR CREMATORY: Mount Moriah Cem.
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: OCT 9 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: John P. Gomez
LICENSE NO.: E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 16 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 31 1985

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4302
Local Reg. No. 261
Reg. Dist. No. 511

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BANNOCK 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): — 000

OCT 9 1967
Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Texas 44
b. COUNTY: Cameron 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lozano
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) NAPOLEON b. (Middle) R. c. (Last) AGUIRRE

4. DATE OF DEATH (Month) (Day) (Year): Oct. 2, 1967

5. SEX: Male
6. COLOR OR RACE: Spanish
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: Dec. 18, 1950
9. AGE (In years last birthday): 16 — IF UNDER 1 YEAR: Months 9, Days 14 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Rio Hondo, Texas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Pedro Aguirre — BIRTHPLACE: Mexico
14. MOTHER'S MAIDEN NAME: Catarina Ramirez — BIRTHPLACE: Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-60-2425
17. INFORMANT'S OWN SIGNATURE: Pedro Aguirre Jr. — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8/61

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Basal Fracture, Skull

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture of Skull, Vault
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE HOMICIDE~~ (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): City Street 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 031 (STATE): Pocatello Bannock Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-2-67 1:25 p.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car-Truck Collision

22. *I hereby certify that I attended the deceased from* —2—, 19__, *to* ——, 19__, *that I last saw the deceased* Dead *on* 10-2, 1967, *and that death occurred at* — m., *from the causes and on the date stated above.*

23a. SIGNATURE: Burton H. John 583 (Degree or title): Coroner 4
23b. ADDRESS: Bannock Co. Idaho
23c. DATE SIGNED: 10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10-5-67
24c. NAME OF CEMETERY OR CREMATORY: Mont Meta Memorial Park
24d. LOCATION (City, town, or county) (State): San Benito, Texas

DATE REC'D BY LOCAL REG.: OCT 5 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: H. L. Davis — LICENSE NO.: E-253

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 25 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 2 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 29 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4303
Local Reg. No. 270
Reg. Dist. No. 511

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 OCT 13 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF [illegible] (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: 390 Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bannock Creek
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First): LEGRAND
b. (Middle): ALLEN
c. (Last): SHAY

4. DATE OF DEATH (Month) (Day) (Year): Oct. 3, 1967

5. SEX: Male
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married /
8. DATE OF BIRTH: Dec. 18, 1964
9. AGE (In years last birthday): 2 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02
10b. KIND OF BUSINESS OR INDUSTRY: xxxx
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Larson Shay — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Emma Bishop — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): xxxx
16. SOCIAL SECURITY NO.: xxxxx
17. INFORMANT'S OWN SIGNATURE: Inez I. Tindore — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Skull fracture, left frontal — INTERVAL BETWEEN ONSET AND DEATH: 1 hr. 20 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Car-Pedestrian accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident /
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hi-way 30 N 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 390 **(STATE)**: 3 mi. west Pocatello Power Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 3, 1967 12:40am
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? wandered on to hiway at night unobserved.

22. *I hereby certify that I attended the deceased from* [illegible] *saw the deceased deceased on* 10-3, 19 67, *and that death occurred at* 2:00a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Bud Kelly — 583 (Degree or title): Coroner 4
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial /
24b. DATE: Oct. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Bannock Creek Cemetery
24d. LOCATION (City, town, or county) (State): Bannock Creek, Idaho

DATE REC'D BY LOCAL REG.: OCT 12 1967
REGISTRAR'S SIGNATURE: Gloria Dopete
25. EMBALMER: F. B. [illegible]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4304
Local Reg. No. 273
Reg. Dist. No. 511

RECEIVED
OCT 19 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN: Pocatello
c. LENGTH OF STAY (in this place): 018
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Wyoming 51
b. COUNTY: Teton 555
c. CITY OR TOWN: Jackson Hole
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): WALTER
b. (Middle): LENOIR
c. (Last): SPICER

4. DATE OF DEATH: Oct. 4, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Nov. 8, 1887

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher and Car Salesman

10b. KIND OF BUSINESS OR INDUSTRY: 04

11. BIRTHPLACE (State or foreign country): Trophill, North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown (Spicer)
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Virginia L. Spicer
ADDRESS: Pocatello, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sep 29, 1967, *to* Sep Oct 4, 1967, *that I last saw the deceased alive on* Oct 4, 1967, *and that death occurred at* 3:20 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 009
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 11 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Jackson Hole Cemetery
24d. LOCATION (City, town, or county) (State): Jackson Hole, Teton, Wyo.

DATE REC'D BY LOCAL REG.: OCT 16 1967
REGISTRAR'S SIGNATURE: Gloria Rizzuto
25. EMBALMER: E. B. Jackson
LICENSE NO.: E418
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 19 1967

JUN 15 1983

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

State File No. 4305
Local Reg. No. 272
Reg. Dist. No. 510

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 03 | OCT 19 1967 | 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 3916 Hawthorne Road

3. NAME OF DECEASED (Type or Print): a. (First) ANDREW b. (Middle) c. (Last) PACKER

4. DATE OF DEATH (Month) (Day) (Year): October 4, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 21, 1909

9. AGE (In years last birthday): 58
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian 06

10b. KIND OF BUSINESS OR INDUSTRY: Public School

11. BIRTHPLACE (State or foreign country): Marsh Center, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Josiah George Packer — BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Solon Chase Wallace — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Lorraine Packer — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Chronic Rheumatic Heart Disease

332 X

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* 10-4-, 1967, *that I last saw the deceased alive on* 10-4, 1967, *and that death occurred at* 2:47 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David C. Miller, M.D. — **23b. ADDRESS**: Pocatello, Idaho — **23c. DATE SIGNED**: 10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Oct. 7, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: McCammon Cemetery — **24d. LOCATION** (City, town, or county) (State): McCammon, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 16 1967 OCT 19

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: [signature] — **LICENSE NO.**: E418

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4306
Local Reg. No. 288
Reg. Dist. No. 5-10

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 2⅔ wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 031 b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 723 W. Lewis

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	LESTER	L	KAUFMAN	Oct.	4	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Dec. 23, 1908	58				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carman 10	Railroad	Laramie, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Kaufman	Missouri	Lillie Perue	Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		712-05-9908	Lulu Kaufman	POCATELLO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2021 Lymphoma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Leukopenia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Duodenal ulcer with hemorrhage

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐ Report not available as of 10-26-67

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* 10-4, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Calvin Buhler	M.D.	107 No. 5th Pocatello Idaho	10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3		Greenhill Cem.	Laramie Wyoming

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 27 1967	Gloria Davis	George W. Knoff	409

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 5 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4307
Local Reg. No. 269
Reg. Dist. No. 510

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

OCT 12 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. STATE OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 780 Yellowstone

3. NAME OF DECEASED (Type or Print)
a. (First): OSCAR
b. (Middle): HAROLD
c. (Last): SHORT

4. DATE OF DEATH (Month) (Day) (Year): Oct. 5, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 3, 1903
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Ucon, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Clarence Short
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Julia Petersen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Robert R. Thor — ADDRESS: Salt Lake City, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion Ac. — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from ——, 19—, to ——, 19—, that I last saw the deceased* death *on* 10-6-1967, *and that death occurred at* ? *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Burton John 583 Coroner 4
23b. ADDRESS: Bannock Co. Idaho
23c. DATE SIGNED: 10-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 11 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. [signature]
LICENSE NO.: E418
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4308
Local Reg. No. 274
Reg. Dist. No. 510

RECEIVED
OCT 19 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1332 East Lander

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) (JACK) c. (Last) WINN

4. DATE OF DEATH (Month) (Day) (Year): October 6, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 24, 1903
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber 21
10b. KIND OF BUSINESS OR INDUSTRY: Barbering
11. BIRTHPLACE (State or foreign country): Preston, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Marion A. Winn — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Rosella Ann Nelson — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Wanda Winn — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1508 Carcinoma of Esophagus with Metastasis — INTERVAL BETWEEN ONSET AND DEATH: 6 month.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Biopsy
20. AUTOPSY? YES [ ] NO [X]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, to 10-6-, 1967, *that I last saw the deceased alive on* 10-6-, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: David C. Miller 363 (Degree or title)
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Victor Cemetery
24d. LOCATION (City, town, or county) (State): Victor, Idaho

DATE REC'D BY LOCAL REG.: OCT 1 - 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: J. B. Nelson — LICENSE NO.: E418

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4309
Local Reg. No. 275
Reg. Dist. No. 510

Certificate of Death

RECEIVED
OCT 19 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 1-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1517 No. Garfield Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1517 No. Garfield Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): HELMUTH
b. (Middle): EMIL 000
c. (Last): WENDLAND

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 29, 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Dept. 10
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Arapahoe, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred Wendland — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Anna Helms — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Minnie H. Wendland — ADDRESS: Pocatello Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 19—, *to* —, 19—, *that I ~~last~~ saw the deceased* ~~alive on~~ 10-7-1967, *and that death occurred at* — *m., from the causes and on the date stated above.*

23a. SIGNATURE: Burton Dohn 583 (Degree or title) Coroner
23b. ADDRESS: Bannock Co. Idaho
23c. DATE SIGNED: 10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 10, '67
24c. NAME OF CEMETERY OR CREMATORY: Mountainview
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: OCT 16 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: George W. Knott
LICENSE NO.: 409

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 31 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4310
Local Reg. No. 271
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA-St.Anthony Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1238 North Harrison

3. NAME OF DECEASED (Type or Print)
a. (First): HORATIO
b. (Middle): J. (RAY) 000
c. (Last): TANNER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 8, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 29, 1900
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lewis Tanner — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Mary Jensen — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Ida L Tanner — ADDRESS: Pocatello, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic Heart disease — 2 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1966, *to* 10-8, 1967, *that I last saw the deceased alive on* 10-5, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R Randall MD 1 123
23b. ADDRESS: 804 E. Center Pocatello
23c. DATE SIGNED: 10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Oct. 12, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 12 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashby — LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4311
Local Reg. No. 276
Reg. Dist. No. 510

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 03 | OCT 19 1967 | 000
b. CITY OR TOWN: Pocatello
c. LENGTH OF STAY IN THIS PLACE: Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03 | b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) EMMA | b. (Middle) 018 | c. (Last) CROFTS

4. DATE OF DEATH: (Month) (Day) (Year): October 8, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Dec. 19, 1884

9. AGE (In years last birthday): 82 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 07

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Mink Creek, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Nels Peter Croney | BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Elsie Christensen | BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): XXXXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mrs. L. N. Nicholls | ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4208

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Old cerebral vascular accident — 4 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 24, 1965, *to* Oct 8 1967, 19___, *that I last saw the deceased alive on* Oct. 8, 1967, *and that death occurred at* 10:20p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. Anderson M.D. 009
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 11 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Basalt Cemetery
24d. LOCATION (City, town, or county) (State): Basalt, Idaho

DATE REC'D BY LOCAL REG.: OCT 16 19
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature]
LICENSE NO.: E418
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4312
Local Reg. No. 290
Reg. Dist. No. 510

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock 019
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 650 McKinley Avenue

3. NAME OF DECEASED (Type or Print): a. (First) NONA b. (Middle) FAYE c. (Last) ROMRIELL

4. DATE OF DEATH: (Month) October (Day) 8 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: February 1, 1938

9. AGE (In years last birthday): 29 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Heber G. Davis — BIRTHPLACE: Mapleton, Idaho

14. MOTHER'S MAIDEN NAME: Laura Hansen — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Lyman H Romriell — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2722X Probable future thrombo-embolism — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Shock & Vascular Collapse

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐ — Examination of patient alone

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, *19*____, *to* Oct. 8, *19* 67, *that I last saw the deceased alive on* Oct. 8, 1967, *and that death occurred at* noon *m., from the causes and on the date stated above.*

23a. SIGNATURE: Calvin Butler M.D. (Degree or title)

23b. ADDRESS: Pocatello, Idaho

23c. DATE SIGNED: Oct. 27, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: OCT 30 1967

REGISTRAR'S SIGNATURE: Glorea Depsta

25. EMBALMER: Jack Henderson — LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4313
Local Reg. No. 277
Reg. Dist. No. 511

BIRTH NO.

OCT 19 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 030 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JESSIE
b. (Middle): 019 PARKER
c. (Last): BLAKESLEE

4. DATE OF DEATH: (Month) October (Day) 9 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: December 15, 1881

9. AGE (In years last birthday): 85
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Ross Fork Creek (Fort Hall) Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A

13. FATHER'S NAME: Hiram Parker
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Mary Dempsey
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: *****

17. INFORMANT'S OWN SIGNATURE: Mrs. Bertha Roubidoux
ADDRESS: Fort Hall, Idah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4668

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute thrombosis internal iliac vessels

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 1 week

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* Oct. 9, 1967, *that I last saw the deceased alive on* Oct. 9, 1967, *and that death occurred at* 6:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 256 (Degree or title)
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Oct. 11, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 12, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sand Hills Cemetery
24d. LOCATION (City, town, or county) (State): Fort Hall, Idaho

DATE REC'D BY LOCAL REGISTRAR: OCT 16 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 31 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 29 1982
AUG 06 1998

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4314
Local Reg. No. 280
Reg. Dist. No. 510

BIRTH NO.

RECEIVED OCT 26 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Community Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 03
b. COUNTY Bannock 019
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 537 N. Main

3. NAME OF DECEASED (Type or Print) a. (First) ERMA b. (Middle) L. c. (Last) HEGSTED

4. DATE OF DEATH (Month) (Day) (Year) Oct. 11, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH May 23, 1906

9. AGE (In years last birthday) 61
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY Family Homes

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Victor C. Hegsted
BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Ada Martin
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-26-2040

17. INFORMANT'S OWN SIGNATURE Geneva Jensen
ADDRESS St. Anthony, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic endometrial carcinoma 1728
INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 22, 1967, to Oct 11, 1967, that I last saw the deceased alive on Oct 11, 1967, and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE J Henderson MD 004 (Degree or title)

23b. ADDRESS Pocatello Idaho

23c. DATE SIGNED 16 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-14-67

24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.

24d. LOCATION (City, town, or county) (State) Pocatello, Idaho

DATE REC'D BY LOCAL REG. OCT 23 1967

REGISTRAR'S SIGNATURE Elora Dopita

25. EMBALMER John P. Gross

LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4315
Local Reg. No. 238
Reg. Dist. No. 510

RECEIVED
OCT 19 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 525 W. Hayden 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 525 W. Hayden

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
AMY	W.	STEWART	Oct. 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	June 20, 1878	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John M. Wilkinson	England	Charlotte Moore	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Georgia Stewart	Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage (Stroke) — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio-Sclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* —, 19—, *to* —, 19—, *that I last saw the deceased alive on* 10-12-, 1967, *and that death occurred at* 12:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton A. John 583	Coroner	Bannock Co. Idaho	10-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-16-67	Mountainview Cem.	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 16 1967	Gloria Boyle	John P. Downard	E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4316
Local Reg. No. 281
Reg. Dist. No. 5-2

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 03
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) LADEANE; b. (Middle); c. (Last) JENSON

4. DATE OF DEATH (Month) (Day) (Year): October 13, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 12, 1920

9. AGE (In years last birthday): 47 | If under 1 year: Months, Days | If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Grace, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leland A. Harris — BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Iris Tanner — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: John R. Jenson — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intra Cranial Malignancy — INTERVAL BETWEEN ONSET AND DEATH: 18 Mo's.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) 1938

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 19 55, *to* 13-X, 1967, *that I last saw the deceased alive on* 13-X 1967, *and that death occurred at* 13:45 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.J.Sharp, M.D. 462

23b. ADDRESS: 15th & Center, Pocatello, IDaho

23c. DATE SIGNED: 10/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 16, 1967

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens

24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.:

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: T. B. Nelson — LICENSE NO.: E418

FIRM NAME: Manning Funeral Chapel

Public Health Service — Form DH-63021

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 10 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4317
Local Reg. No. 282
Reg. Dist. No. 510

BIRTH NO.

OCT 26 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Mercy Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 960 West Clark Street

3. NAME OF DECEASED (Type or Print): a. (First) ALBERT b. (Middle) c. (Last) HARD

4. DATE OF DEATH: (Month) October (Day) 14 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: August 29, 1877

9. AGE (In years last birthday): 90 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer - Locomotive

10b. KIND OF BUSINESS OR INDUSTRY: 10 Union Pacific R.R.

11. BIRTHPLACE (State or foreign country): Witt Township, Illinois

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: William S. Hard
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Donaldson
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 712-05-3253

17. INFORMANT'S OWN SIGNATURE: (s) Mrs. Cecil Hard,
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 4, 1967 *to* Oct. 14, 1967, *that I last saw the deceased alive on* Oct. 14, 1967, *and that death occurred at* 3:05 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 123 (Degree or title) MD

23b. ADDRESS: Pocatello, Idaho

23c. DATE SIGNED: Oct. 17, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 17, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: OCT 26 1967

REGISTRAR'S SIGNATURE: Gloria Davis

25. EMBALMER: Jack Henderson

LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4318
Local Reg. No. 283
Reg. Dist. No. 510

Certificate of Death

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 262 Washington

3. NAME OF DECEASED (Type or Print)
a. (First): JOSEPH
b. (Middle): SMITH
c. (Last): GRAHAM

4. DATE OF DEATH (Month) (Day) (Year): Oct. 15, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov. 23, 1896
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Machinist 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Payson, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME / BIRTHPLACE: James Graham
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Jane Laird

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Gladys Graham — ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Glomerulonephritis, nephrosclerosis, and pyelonephritis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b): Hemorrhagic pneumonia
~~DUE TO~~ (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic heart disease

INTERVAL BETWEEN ONSET AND DEATH

446X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Calvin Buhler, M.D. 069 1
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Oct.18,1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem.Gardens
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 25 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4319
Local Reg. No. 286
Reg. Dist. No. 5-11

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 OCT 27 1967 Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write township) Pocatello
LENGTH OF STAY (in this place) 3 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCammon 030
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	REUBEN	FRED	LINDENSCHMIDT	Oct. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	July 4, 1886	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Manager, Owner 26	Garage	Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George A. Lindenschmidt	Germany	Louise Nissley	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-18-6876	Mildred Lendenschmidt	McCammon, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Renal failure — INTERVAL BETWEEN ONSET AND DEATH: sev. days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 28, 1957, *to* Oct. 18, 1967, *that I last saw the deceased alive on* Oct. 18, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. S. Call	M.D.	P. O. Box 852	10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-21-67	Harkness Cem.	McCammon, Idaho

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
OCT 26 1967	Gloria Dozta	John P. Thomas	E-292

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Downard Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4320
Local Reg. No. 284
Reg. Dist. No. 510

BIRTH NO. OCT 26 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 618 South 4th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): STERLING
b. (Middle): LEEROY 294
c. (Last): ADAMS

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 21, 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY: Carpentry
11. BIRTHPLACE (State or foreign country): Formoso, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Charles E. Adams
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Lillie Smith

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I
16. SOCIAL SECURITY NO.: 516 14 7706A
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Lela J. Adams

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5271

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Cor Pulmonale — 5 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-12, 1963, *to* 10-18, 1967, *that I last saw the deceased alive on* 10-18, 1967, *and that death occurred at* 6A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Randall MD
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 10-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 23 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashley — LICENSE NO. E418

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Manning Funeral Chapel

OCT 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4321
Local Reg. No. 289
Reg. Dist. No. 5-10

Certificate of Death

RECEIVED

BIRTH NO. STATE OF IDAHO

OCT 30 1967
Bureau of Vital Statistics

1. PLACE OF DEATH 031
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF [illegible] (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 1433 North Arthur

3. NAME OF DECEASED (Type or Print)
a. (First): PARLEY
b. (Middle): L.
c. (Last): CARVER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 31, 1891
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber 21
10b. KIND OF BUSINESS OR INDUSTRY: Barbering
11. BIRTHPLACE (State or foreign country): Plain City, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Parley P. Carver — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Elizabeth Pritchett — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Hazle S. Carver — ADDRESS:

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 11, 1963, *to* Oct. 18, 1967, *that I last saw the deceased alive on* Oct. 18, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 077 (Degree or title): L. S. Call, MD
23b. ADDRESS: P. O. Box 852
23c. DATE SIGNED: 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery
24d. LOCATION (City, town, or county) (State): Preston, Franklin, Idaho

DATE REC'D BY LOCAL REG.: OCT 27 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashby — LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4322
Local Reg. No. 285
Reg. Dist. No. 510

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 031 OCT 26 1967
a. COUNTY Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello 031
d. STREET ADDRESS (If rural, give location) 830 North Harrison

3. NAME OF DECEASED (Type or Print) a. (First) MYRON b. (Middle) c. (Last) HUDSON

4. DATE OF DEATH (Month) (Day) (Year) Oct. 19, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 4
8. DATE OF BIRTH July 6, 1888
9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY Carpentry
11. BIRTHPLACE (State or foreign country) Lehi, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Otto Hudson BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Martha Jane Dorton BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War I 3
16. SOCIAL SECURITY NO. 519 03 9652
17. INFORMANT'S OWN SIGNATURE x Mary Barbour ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH 1401
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, Metastatic

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Primary on lower lip.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Burton Johns 583 (Degree or title) Coroner 4
23b. ADDRESS Bannock Co. Idaho
23c. DATE SIGNED 10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE Oct. 24, 1967
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL OCT 25 1967
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER F. B. Ashby
LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4323
Local Reg. No. 291
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH 031 NOV 1 1967

a. COUNTY: Bannock

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello

Bureau of Vital Statistics

STATE FILE NO. / STAY (in this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bannock

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall 030

d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)

a. (First): WILLIE

b. (Middle):

c. (Last): EDMO

4. DATE OF DEATH (Month) (Day) (Year): October 20, 1967

5. SEX: Male

6. COLOR OR RACE: Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 4, 1888

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Interpreter 30

10b. KIND OF BUSINESS OR INDUSTRY: Indian Agency

11. BIRTHPLACE (State or foreign country): Fort Hall, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Tom Edmo — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Melina Depoe — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXX

16. SOCIAL SECURITY NO.: 513 36 3284

17. INFORMANT'S OWN SIGNATURE: Irene P Edmo — ADDRESS: Fort Hall, Idaho

18. CAUSE OF DEATH 4200

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): ~~CH~~ Congestive heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 8-25-67

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerotic heart disease — 10-20-67

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Cardiac cirrhosis

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25, 1967, *to* 10-20, 1967, *that I last saw the deceased alive on* 10-20, 1967, *and that death occurred at* 1-3 p m., *from the causes and on the date stated above.*

23a. SIGNATURE 774 (Degree or title): Michael Worona MD

23b. ADDRESS: KASISKA BLDG / Box 852 POCATELLO

23c. DATE SIGNED: 10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 25, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mission Cemetery

24d. LOCATION (City, town, or county) (State): Fort Hall, Idaho

DATE REC'D BY LOCAL REG.: OCT 31 1967

REGISTRAR'S SIGNATURE: Gloria Sopita

25. EMBALMER: F. B. Ashby — LICENSE NO. E418

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4324
Local Reg. No. 292
Reg. Dist. No. 511

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Mem. Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Ft.Hall Indian Res. 030
d. STREET ADDRESS (If rural, give location) Ft. Hall Indian Reservation

3. NAME OF DECEASED (Type or Print)
a. (First) ANNIE
b. (Middle) HOPE
c. (Last) KAKA

4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1967

5. SEX Female
6. COLOR OR RACE Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 1898
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charlie Hope — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Lucy Use — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Wallace Kaka — ADDRESS Ft. Hall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) LIVER FAILURE - CIRRHOSIS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Malnutrition.
DUE TO (c) Decrease. Food intake.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
1) Hypoproteinemia.
2) Bilateral pleural effusion

INTERVAL BETWEEN ONSET AND DEATH
10-11-67
10-21-67

19a. DATE OF OPERATION none
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-11, 1967, *to* 10-21, 1967, *that I last saw the deceased alive on* 10-21, 1967, *and that death occurred at* 9 *m., from the causes and on the date stated above.*

23a. SIGNATURE Michael Wonona 774 (Degree or title) MD.
23b. ADDRESS Box 852 KASISKA BLDY POCATELLO
23c. DATE SIGNED 10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-24-67
24c. NAME OF CEMETERY OR CREMATORY Ross Fork Cem.
24d. LOCATION (City, town, or county) (State) Bingham County, Idaho

DATE REC'D BY LOCAL REG. OCT 31 1967
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER John P. Gomez
LICENSE NO. E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4325
Local Reg. No. 287
Reg. Dist. No. 510

RECEIVED
OCT 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Anthony Community Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello 031
d. STREET ADDRESS (If rural, give location) 1034 Malibu

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) JOHANNA 019 c. (Last) RUPP

4. DATE OF DEATH (Month) (Day) (Year) Oct. 22, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 23, 1929
9. AGE (In years last birthday) 37 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel J. Jarvis BIRTHPLACE Penna,
14. MOTHER'S MAIDEN NAME Velma Lewis BIRTHPLACE Penna.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 173-24-5704
17. INFORMANT'S OWN SIGNATURE Norma Rupp ADDRESS Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Spontaneous intercranial hemorrhage, cause undetermined.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Obstructed breathing
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Obstructed breathing

INTERVAL BETWEEN ONSET AND DEATH: 4 days

331X

19a. DATE OF OPERATION: 10-20-67
19b. MAJOR FINDINGS OF OPERATION: Tracheostomy
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-19 1967 *to* 10-22-, 1967, *that I last saw the deceased alive on* 10-22 1967, *and that death occurred at* 5:00 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Arch Wigle, MD 566 (Degree or title)
23b. ADDRESS 1605 N. Arthur, Pocatello Idaho
23c. DATE SIGNED 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-25-67
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) (State) Pocatello, Idaho

DATE REC'D BY LOCAL REG. OCT 26 1967
REGISTRAR'S SIGNATURE Gloria Rogers
25. EMBALMER John P. Downard
LICENSE NO. E-292
FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4326
Local Reg. No. 294
Reg. Dist. No. 510

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 031
NOV 6 1967
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY IN (this place): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 635 No. 13th

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hosp. 019

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) W. c. (Last) O'BRIEN

4. DATE OF DEATH (Month) (Day) (Year): Oct. 24, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 14, 1928

9. AGE (In years last birthday): 39
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John O'Brien
BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Gladys Fern Burdette
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War II

16. SOCIAL SECURITY NO.: 722-14-8699

17. INFORMANT'S OWN SIGNATURE: Delora O'Brien
ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2843

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: few hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute myelogenous leukemia — sev. mnths.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 27, *1967, to* Oct. 24, *19 67, that I last saw the deceased alive on* 7pm 10-23 *19 67 and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: John L. Comstock 10 (Degree or title): J.E. Comstock, M.D.

23b. ADDRESS: P. O. Box 852

23c. DATE SIGNED: 10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-27-67

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem

24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: NOV 1 1967

REGISTRAR'S SIGNATURE: Elona Doputa

25. EMBALMER: John P. Gronna
LICENSE NO.: E-292
FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 7 1967

FEB 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4327
Local Reg. No. 293
Reg. Dist. No. 510

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

031 NOV 1 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 174 Oakland Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): LEWIS
b. (Middle): FRANKLIN
c. (Last): FARNSWORTH

4. DATE OF DEATH (Month) (Day) (Year): October 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 13, 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Beaver, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lewis Edwin Farnsworth — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Amelia Abigail White — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Rosetta Farnsworth — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-15, 1967, *to* 10-25, 1967, *that I last saw the deceased alive on* 10-25, 1967, *and that death occurred at* 8 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: R Grandall MD (Degree or title)
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 10-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: OCT 31 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 12 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4328
Local Reg. No. 297
Reg. Dist. No. 510

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 NOV 9 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 219 North Grant

3. NAME OF DECEASED (Type or Print)
a. (First): WOODROW
b. (Middle): "BILL" W.
c. (Last): LINDSEY

4. DATE OF DEATH (Month) (Day) (Year): October 26, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 29, 1913
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heavy equipment operator!!
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Lindsey — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Mary Jane — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 10 0238
17. INFORMANT'S OWN SIGNATURE: J. Alta Lindsey — ADDRESS: Pocatello, Ida

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): acute coronary thrombosis
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): acute myocardial failure, acute pulmonary embolus.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Chronic Rheumatic Gent Disease

INTERVAL BETWEEN ONSET AND DEATH: 10 days
yes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 10-26-, 1967, *that I last saw the deceased alive on* 10-26, 1967, *and that death occurred at* 6 m., *from the causes and on the date stated above.*

23a. SIGNATURE: David C. Miller, Jr. 362 (Degree or title)
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: NOV 6 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashley
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 4 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4329
Local Reg. No. 298
Reg. Dist. No. 510

BIRTH NO.

NOV 9 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 230 W. Bonneville

3. NAME OF DECEASED (Type or Print): a. (First) JOE b. (Middle) C. c. (Last) CARRAL (MEDIA)

4. DATE OF DEATH (Month) (Day) (Year): Oct. 26, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Feb. 24, 1899

9. AGE (In years last birthday): 68 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheepman 04

10b. KIND OF BUSINESS OR INDUSTRY: Sheep Raising

11. BIRTHPLACE (State or foreign country): Spain

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unk. Carrall
BIRTHPLACE: Spain

14. MOTHER'S MAIDEN NAME: Unk. Media
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Unknown

16. SOCIAL SECURITY NO.: 519-24-0804

17. INFORMANT'S OWN SIGNATURE: Clara Equibar
ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, Larynx — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS (*Conditions contributing to the death but not related to the disease or condition causing death.*) Tracheo-esophageal fistula due to erosion of neoplasm

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* Oct, 1967, *that I last saw the deceased alive on* Oct 25, 1967, *and that death occurred at* 8:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] MD 158 (Degree or title)

23b. ADDRESS: 322 Jefferson Pocatello

23c. DATE SIGNED: 11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-28-67

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem.

24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: NOV - 1967

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: John P. Downard

LICENSE NO.: E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4330
Local Reg. No. 302
Reg. Dist. No. 511

Certificate of Death

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Inkom 030
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ERNEST
b. (Middle): JAMES
c. (Last): GARDNER

4. DATE OF DEATH (Month) (Day) (Year): October 29, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 26, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer 22
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles W. Gardner — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Sarah Ann Ashton — BIRTHPLACE: Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1920-1924 3
16. SOCIAL SECURITY NO.: 505 0305994
17. INFORMANT'S OWN SIGNATURE: Dieguez C. Gardner — ADDRESS: Inkom, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Prostate Gland with Bone Metastases — INTERVAL BETWEEN ONSET AND DEATH: 5+ yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 10-29-, 1967, *that I last saw the deceased alive on* 10-29-, 1967, *and that death occurred at* 8P *m., from the causes and on the date stated above.*

23a. SIGNATURE: D. Miller, Mil. 362 (Degree or title)
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY: Inkom Cemetery
24d. LOCATION (City, town, or county) (State): Inkom, Bannock, Idaho

DATE REC'D BY LOCAL REG.: NOV 9 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Jolley — LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4331
Local Reg. No. 295
Reg. Dist. No. 510

Certificate of Death

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. STATE OF DEATH (In this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 150 16th Place

3. NAME OF DECEASED (Type or Print)
a. (First): MABEL
b. (Middle): ELLEN
c. (Last): REITER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 29, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 14, 1905
9. AGE (In years last birthday): 61 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Barnard — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Margaret Munden — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 562-1202059
17. INFORMANT'S OWN SIGNATURE: Lyle F Reiter — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease, Cardiac failure, Terminal uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept., 1967, *to* 10-24-, 1967, *that I last saw the deceased alive on* 10-24-67, 19__, *and that death occurred at* 8 A m. *from the causes and on the date stated above.*

23a. SIGNATURE: David C. Miller, 362 (Degree or title) June 1
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-2-67
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: NOV 2 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: John P. Grover
LICENSE NO.: E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 12 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 18 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4332
Local Reg. No. 311
Reg. Dist. No. 511

Certificate of Death

RECEIVED
NOV 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (If in hospital or institution, give street address or location): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grace 150
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ARLETTA
b. (Middle): 294
c. (Last): BOLLWINKEL

4. DATE OF DEATH (Month) (Day) (Year): October 30, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Oct. 5, 1872
9. AGE (In years last birthday): 95 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Granger, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Lucius Augustus Peck
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Evalyn Roundy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Theron Miller

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Osteoporosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 11:45 a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Calvin Buhler MD 068
23b. ADDRESS: 1
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 7
24b. DATE: Nov. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Thatcher Cemetery
24d. LOCATION (City, town, or county) (State): Thatcher, Caribou, Idaho

DATE REC'D BY LOCAL REG.: Nov 1967
REGISTRAR'S SIGNATURE: Blanca Dopita
25. EMBALMER: F. B. Ashley
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4333
Local Reg. No. 299
Reg. Dist. No. 510

RECEIVED
NOV 9 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 031 321
a. COUNTY Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 5 WKS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Anthony Community Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 031 Pocatello
d. STREET ADDRESS (If rural, give location) 409 No. 7th

3. NAME OF DECEASED (Type or Print)
a. (First) DANTE
b. (Middle) 014
c. (Last) FRUGOLI

4. DATE OF DEATH (Month) (Day) (Year) Oct. 31, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 24, 1896
9. AGE (In years last birthday) 70 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boilermaker 10
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Emil Frugoli
BIRTHPLACE Italy
14. MOTHER'S MAIDEN NAME Mary Cardinale
BIRTHPLACE Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 712-03-4822
17. INFORMANT'S OWN SIGNATURE Julie Frugoli
ADDRESS Pocatello, Ida.

18. CAUSE OF DEATH 1538
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Debility and weight loss

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Liver failure
DUE TO (c) Adenocarcinoma of colon with spread to liver

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Abdominal ascites

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION Jan 27, 1967
19b. MAJOR FINDINGS OF OPERATION Adenocarcinoma of colon with spread to liver
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 25, 1967, *to* Oct. 31, 1967, *that I last saw the deceased alive on* Oct 30, 1967, *and that death occurred at* 1:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 493 (Degree or title) H.K. Staheli, M.D. 1
23b. ADDRESS 246 N. 18, Pocatello, Idaho
23c. DATE SIGNED Nov. 1, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-2-67
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) (State) Pocatello, Idaho

DATE REC'D BY LOCAL REG. NOV 8 1967
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER John P. Gomez
LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 10 1967

MAR 8 1982

FEB 11 1987

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4334
Local Reg. No. 300
Reg. Dist. No. 511

Certificate of Death

RECEIVED
NOV 9 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cloverdell Motel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell 141
d. STREET ADDRESS (If rural, give location): 1005 Elgin

3. NAME OF DECEASED (Type or Print)
a. (First): Lemuel
b. (Middle):
c. (Last): Maxwell

4. DATE OF DEATH (Month) (Day) (Year): Oct. 31, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 14, 1925
9. AGE (In years last birthday): 42 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Cape Fair, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Maxwell — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Ella Crabtree — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): War II 4
16. SOCIAL SECURITY NO.: 518-22-0417
17. INFORMANT'S OWN SIGNATURE: Helen M. Maxwell — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased* ~~alive~~ *on* 10-31-, 1967, *and that death occurred at* 6 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Bertha Holm — 583 (Degree or title): Coroner & Bannock Co. Ida
23b. ADDRESS:
23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mem. Garden
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: NOV 6 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 21 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4335
Local Reg. No. 312
Reg. Dist. No. 510

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 031 NOV 21 1967
a. COUNTY Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Nursing Home 299

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello 031
d. STREET ADDRESS (If rural, give location) 101 Foothill Blvd.

3. NAME OF DECEASED (Type or Print)
a. (First) EVELYN
b. (Middle) G.
c. (Last) MARSH

4. DATE OF DEATH (Month) October (Day) 31 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 2 1889
9. AGE (In years last birthday) 78 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse 13
10b. KIND OF BUSINESS OR INDUSTRY Nursing
11. BIRTHPLACE (State or foreign country) Bedham Maine
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Granville Goodwin BIRTHPLACE Mariaville,, Maine
14. MOTHER'S MAIDEN NAME Nettie Burrill BIRTHPLACE Dedham, Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) *****
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Joyce M Alenski ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH 1-2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 10 yrs
DUE TO (c) Hypertension — - 5 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1965, *to* Oct. 31, 1967, *that I last saw the deceased alive on* Oct. 31, 1967, *and that death occurred at* 1:45 a.m. *from the causes and on the date stated above.*

23a. SIGNATURE R. E. Ostler MD (Degree or title) R. E. Ostler, M.D. 400
23b. ADDRESS Pocatello, Idaho
23c. DATE SIGNED Nov. 2, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE Nov. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY Aultorest Memorial Corp.
24d. LOCATION (City, town, or county) Ogden (State) Utah

DATE REC'D BY LOCAL REG. NOV 20 1967
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER Jack Henderson
LICENSE NO. E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4336
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 19 1967

Bureau of Vital Statistics

1. PLACE OF DEATH 040
a. COUNTY Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Ida.
c. LENGTH OF STAY (If in hospital) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital
2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho 040
d. STREET ADDRESS (If rural, give location) 940 Monroe St.

3. NAME OF DECEASED (Type or Print)
a. (First) Ruth
b. (Middle) W.
c. (Last) Dunn

4. DATE OF DEATH (Month) (Day) (Year) Oct 10 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 14, 1909
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Sales Lady in Dry Store
10b. KIND OF BUSINESS OR INDUSTRY 25
11. BIRTHPLACE (State or foreign country) Afton Wyoming
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Noen Wilkes — BIRTHPLACE St Charles Ida
14. MOTHER'S MAIDEN NAME Mary B. Lindsay — BIRTHPLACE Deweyville Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-26-3287
17. INFORMANT'S OWN SIGNATURE Merlin Dunn — ADDRESS Montpelier Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

151X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer Stomach — INTERVAL BETWEEN ONSET AND DEATH: Uncertain

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 6-14-67
19b. MAJOR FINDINGS OF OPERATION Cancer Stomach
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 6, 1967, *to* Oct 10, 1967, *that I last saw the deceased alive on* Oct 10, 1967 *and that death occurred at* 1:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Alfred Rich MD (Degree or title) 439
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 13 1967
24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery
24d. LOCATION (City, town, or county) (State) Montpelier Idaho

DATE REC'D BY LOCAL REG. 10-17-1967
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinsky
25. EMBALMER Vile Matthews
LICENSE NO. E 359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4337
Local Reg. No.
Reg. Dist. No. 552

RECORD Certificate of Death

STATE OF IDAHO

BIRTH NO.

NOV 1 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho 040
d. STREET ADDRESS (If rural, give location) 421 N. 3rd Street

3. NAME OF DECEASED (Type or Print)
a. (First) Baby
b. (Middle) 024
c. (Last) Long

4. DATE OF DEATH (Month) (Day) (Year) Oct. 25 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Oct. 25 1967
9. AGE (In years last birthday) Never Lived — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Montpelier Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME LeRoy Long — BIRTHPLACE Sheridan Wyoming
14. MOTHER'S MAIDEN NAME Judy Burland St. — BIRTHPLACE Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE LeRoy Long — ADDRESS Montpelier Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7593

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malformation

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Paul H. Gaines 126 (Degree or title) M.D.
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 26 1967
24c. NAME OF CEMETERY OR CREMATORY Montpelier Cemetery
24d. LOCATION (City, town, or county) (State) Montpelier Idaho

DATE REC'D BY LOCAL REG. 10-27-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinski
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4338
Local Reg. No. 41
Reg. Dist. No. 130

BIRTH NO.

RECEIVED OCT 16 1967 Bureau of Vital Statistics

1. PLACE OF DEATH 050 3/3
a. COUNTY Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (in this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 225 Benewah Community Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 050 Rocky Point
d. STREET ADDRESS (If rural, give location) General Delivery

3. NAME OF DECEASED (Type or Print) a. (First) Chas. b. (Middle) --- c. (Last) Johnson

4. DATE OF DEATH (Month) October (Day) 3 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 4
8. DATE OF BIRTH July 4, 1874
9. AGE (In years last birthday) 93 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Construction 04
10b. KIND OF BUSINESS OR INDUSTRY Ranching & Railroad
11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-10-5734
17. INFORMANT'S OWN SIGNATURE Mrs Conrad Nelson ADDRESS Seattle Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4301

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gangrene left leg — INTERVAL BETWEEN ONSET AND DEATH 3 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10-2-67
19b. MAJOR FINDINGS OF OPERATION Gangrene right leg - mid thigh amputation
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1967, *to* Oct 3, 1967, *that I last saw the deceased alive on* 10-3, 1967, *and that death occurred at* 7:20 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE B. A. Rapp (Degree or title) 428 M.D.
23b. ADDRESS St. Maries, Idaho
23c. DATE SIGNED 10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/7/67
24c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery
24d. LOCATION (City, town, or county) St. Maries (State) Idaho

DATE REC'D BY LOCAL REG. 10-11-67
REGISTRAR'S SIGNATURE Wanda Dimics
25. EMBALMER Gerald Browning
LICENSE NO. E-411
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4339
Local Reg. No. 42
Reg. Dist. No. 130

BIRTH NO.

RECEIVED OCT 16 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Benewah 050 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
c. LENGTH OF STAY (in this place): 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Comm. Hosp 025

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 400
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Calder
d. STREET ADDRESS (If rural, give location): —

3. NAME OF DECEASED (Type or Print)
a. (First): Richard
b. (Middle): Earl
c. (Last): Sibert

4. DATE OF DEATH (Month) (Day) (Year): Oct. 5 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 12, 1884
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming 04
10b. KIND OF BUSINESS OR INDUSTRY: Diversified
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: No information
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: No information

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-03-4763
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Mrs. W. D. Laing, Longview Wn.

18. CAUSE OF DEATH 260X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 38 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Diabetes Mellitus — 10 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 400 (STATE): Calder (Shoshone) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Aug 28 1967 A.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Tractor went off highway

22. *I hereby certify that I attended the deceased from* 3 Jan 2, 1957, *to* 5 Oct, 1967, *that I last saw the deceased alive on* 4 Oct, 1967, *and that death occurred at* 6:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): E. Sullivan MD 511
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 6 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: 10-11-67
REGISTRAR'S SIGNATURE: Wanda Dimiss
25. EMBALMER: Gerald Browning
LICENSE NO.: E-41

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4340
Local Reg. No. 43
Reg. Dist. No. 130

BIRTH NO.

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN: St. Maries
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Home, R.4 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries 050
d. STREET ADDRESS (If rural, give location): Route #4

3. NAME OF DECEASED (Type or Print): a. (First) Scott; b. (Middle) Collin; c. (Last) Reed

4. DATE OF DEATH: (Month) October (Day) 8 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: June 21, 1967

9. AGE (In years last birthday): If under 1 year — Months: 3; Days: ; If under 24 hrs. — Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jerry Reed — BIRTHPLACE: Washington

14. MOTHER'S MAIDEN NAME: Margie Owings — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Jerry Reed — ADDRESS: Rt 4 St. Maries

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE ? (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 11:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 511 (Degree or title)

23b. ADDRESS: St. Maries, Idaho

23c. DATE SIGNED: 10 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: 10-24-67

REGISTRAR'S SIGNATURE: Vanda Dimies

25. EMBALMER: Gerald E Browning — LICENSE NO.: E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: D-67-5316

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

NOV 1 1967

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4341
Local Reg. No. 45
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Benewah (030) — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries (321) — c. LENGTH OF STAY (in this place): 21 days — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Benewah Comm. Hosp. 825

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Benewah — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries (050) — d. STREET ADDRESS (If rural, give location): Rt 2

3. NAME OF DECEASED (Type or Print): a. (First) Oscar — b. (Middle) W. — c. (Last) BLAKE

4. DATE OF DEATH: (Month) Oct (Day) 21 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Dec. 1, 1889

9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Woods work

10b. KIND OF BUSINESS OR INDUSTRY: Logging 17

11. BIRTHPLACE (State or foreign country): Oregon

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George A. Blake — BIRTHPLACE: No data

14. MOTHER'S MAIDEN NAME: Belle Brierley — BIRTHPLACE: No data

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-24-1177

17. INFORMANT'S OWN SIGNATURE: Jessie Weller — ADDRESS: Bremerton Wn.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death: Cardiac decompensation — 2 yrs

332X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1967, *to* Oct 21, 1967, *that I last saw the deceased alive on* Oct 21, 1967, *and that death occurred at* 3¼ a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: B. A. Rapp (428) (Degree or title): M.D. — 23b. ADDRESS: St. Maries, Idaho — 23c. DATE SIGNED: 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation — 24b. DATE: Oct 24, 1967 — 24c. NAME OF CEMETERY OR CREMATORY: Harper Keeper — 24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 10-30-67 — REGISTRAR'S SIGNATURE: Wanda Divine — 25. EMBALMER: Gerald E Browning E-411 — LICENSE NO.

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4342
Local Reg. No. 44
Reg. Dist. No. 130

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Benewah 050 316
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (in this place) 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Comm. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries 050
d. STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print) a. (First) Ruby b. (Middle) W. 025 c. (Last) Everhart

4. DATE OF DEATH (Month) (Day) (Year) Oct. 22 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Oct 2, 1883
9. AGE (In years last birthday) 84 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Registered Nurse
10b. KIND OF BUSINESS OR INDUSTRY Portland Sanitarium 13
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hiram G. Wright BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Mary E. Patterson BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 543-18-5223
17. INFORMANT'S OWN SIGNATURE Donald J. Hanzy ADDRESS St. Maries

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Repeated cerebral vascular accidents — INTERVAL BETWEEN ONSET AND DEATH 17 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 11, 1967, *to* Oct 22, 1967, *that I last saw the deceased alive on* Oct 22, 1967, *and that death occurred at* 12 10/75 *m., from the causes and on the date stated above.*

23a. SIGNATURE W. I. Thurston 533 (Degree or title) MD
23b. ADDRESS St. Maries Idaho
23c. DATE SIGNED 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Oct 24, 1967
24c. NAME OF CEMETERY OR CREMATORY Portland Memorial
24d. LOCATION (City, town, or county) (State) Portland, Oregon

DATE REC'D BY LOCAL REG. 10-30-67
REGISTRAR'S SIGNATURE Wanda Dimiss
25. EMBALMER Gerald Browning LICENSE NO. E 411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4343
Local Reg. No. 126
Reg. Dist. No. 600

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

BIRTH NO. 061 302

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN: Blackfoot
c. LENGTH OF STAY IN THIS PLACE: 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Unknown 100
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	GEORGE	D.	THOMAS	October 1 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never married	August 10 1899	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown 00		Greece	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes (Greek Army) 6	535-07-0169	Mary Payne	Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Arteriosclerosis heart condition 14200	?
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Generalized arteriosclerosis	?

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 29 Sept., 1967, *to* 1 Oct., 1967, *that I last saw the deceased alive on* 1 Oct., 1967, *and that death occurred at* 1:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Leon F. Malouf 594	M.D.	State Hospital South-Blackfoot, Idaho	20 Oct. 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	October 3, 67	State Hospital	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 18, 1967	Dorothy J. Jones	C. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4344
Local Reg. No. 134
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 2 9 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 200
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley, Idaho 060
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Sarah Ann		Jackson	Oct	7	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	7 Aug 1868	99				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Hyrum Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Wilborin	Not Known	Mary Ellen Ward	Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	581-60-2030	Electrice Peterson	Shelley, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4221

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial disease	10 years
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerosis, generalized	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Tumor, non-obstructing, of abdomen	3 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb 13, 1967, *to* Oct 7, 1967, *that I last saw the deceased alive on* Oct 7, 1967, *and that death occurred at* 9:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
234 Walter L Hoge MD 1		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11 Oct 1967	Goshen	Shelley, R#1 Bingham Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 13 1967	Dorothy J. Jones	Lloyd M Nadin	E 275

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 20 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4345
Local Reg. No. 125
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 2 ½ years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham County nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural) 061
d. STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print): a. (First) AUGUSTA b. (Middle) MAY c. (Last) WILLIAMS

4. DATE OF DEATH: (Month) October (Day) 7 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	divorced	May 18, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Wellington, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard L. Smith	Beaver, Utah	Henereta A. Hill	Huntsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			Renay Jacobson	Blackfoot, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia	48 hrs.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Repeated small strokes	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes mellitus	5 years

3344

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9 May, 1960, *to* Oct 7, 1967, *that I last saw the deceased alive on* Oct 7, 1967, *and that death occurred at* 6 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Walter L Hoge 234	M.D.	Blackfoot, Idaho	Oct 9, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct 11, 1967	Riverside-Thomas cemetery	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 18, 1967	Dorothy J Jones	C. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

OCT 24 1967

JUN 30 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4346
Local Reg. No. 18
Reg. Dist. No. 500-604

BIRTH NO.

OCT 17 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 001

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen 060
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) BARBARA
b. (Middle) BAER
c. (Last) HEGE

4. DATE OF DEATH (Month) (Day) (Year) Oct. 7, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Feb. 11, 1874

9. AGE (In years last birthday) 93
IF UNDER 1 YEAR: Months 7 Days 26
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY home

11. BIRTHPLACE (State or foreign country) Baden, Germany

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Baer
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Barbara Heer
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-52-9648

17. INFORMANT'S OWN SIGNATURE Herbert J. Hege
ADDRESS Aberdeen, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1588

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acidosis due to dehydration — 36 hours.
DUE TO (c) Metastatic carcinoma — termined.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
(Omental metastases, Primary — not de-
Cardiac decompensation — 3 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION None

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1940, *to* Oct. 7, 1967, *that I last saw the deceased alive on* Oct. 6, 1967, *and that death occurred at* 11:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE F. L. Harms 203 (Degree or title) M.D.

23b. ADDRESS American Falls, Idaho

23c. DATE SIGNED 9-Oct.1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem.&Burial

24b. DATE 10-10-67

24c. NAME OF CEMETERY OR CREMATORY Homestead Cemetery

24d. LOCATION (City, town, or county) Aberdeen, (State) Idaho

DATE REC'D BY LOCAL REG. 10-13-67

REGISTRAR'S SIGNATURE Carleen Hadfield

25. EMBALMER H. L. Davis

LICENSE NO. E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4347
Local Reg. No. 133
Reg. Dist. No. 600

BIRTH NO.

RECEIVED OCT 17 1967 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY 061 Bingham 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 5yr 7mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett 231
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print) a. (First) DELMAS b. (Middle) A. c. (Last) ANDERSON

4. DATE OF DEATH (Month) (Day) (Year) October 10 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH July 18 1907
9. AGE (In years last birthday) 60 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Electrician
10b. KIND OF BUSINESS OR INDUSTRY 04
11. BIRTHPLACE (State or foreign country) Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Frank Anderson — BIRTHPLACE Georgia
14. MOTHER'S MAIDEN NAME Sarah Petersen — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 530 03 8021
17. INFORMANT'S OWN SIGNATURE Mary Louise ADDRESS Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4201 (b) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
(a) DUE TO (b) Coronary occlusion — 2-3 hrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. A chorea athetosis of yrs' standing but no family hist. of Huntington's disease

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 Sept., 19 67, *to* 10 Oct., 19 67, *that I last saw the deceased alive on* 10 Oct., 1967, *and that death occurred at* 7 a m., *from the causes and on the date stated above.*

23a. SIGNATURE Mary Louise Smith, M.D. 594 (Degree or title)
23b. ADDRESS State Hospital South-Blackfoot, Idaho
23c. DATE SIGNED 11 Oct. '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-16-67
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State) Emmett, Gem, Idaho

DATE REC'D BY LOCAL REG. Oct. 16, 1967
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER Howard Packham
LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4348
Local Reg. No. 128
Reg. Dist. No. 600

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mackay
d. STREET ADDRESS (If rural, give location): 190

3. NAME OF DECEASED (Type or Print): a. (First) ERNEST b. (Middle) GARFIELD c. (Last) HOCKING

4. DATE OF DEATH: (Month) (Day) (Year): October 11, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Feb. 20, 1888

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY: Carpentry

11. BIRTHPLACE (State or foreign country): Park City, Utah

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: Richard Hocking
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Kate Goldsworthy
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-18-4307

17. INFORMANT'S OWN SIGNATURE: X Jean Hocking
ADDRESS: Mackay, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremic Poisoning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Decompensation
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 8-14, 1967, to 10-11, 1967, that I last saw the deceased alive on 10-11, 1967, and that death occurred at 6:45p m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): A. E. Miller M.D.

23b. ADDRESS: Blackfoot Idaho

23c. DATE SIGNED: 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-14-67

24c. NAME OF CEMETERY OR CREMATORY: Mt. McCaleb Cemetery

24d. LOCATION (City, town, or county) (State): Mackay, Idaho

DATE REC'D BY LOCAL REG.: Oct. 27 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jonesta

25. EMBALMER: E. H. Marvel

LICENSE NO.: E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4349
Local Reg. No. 127
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
OCT 20 1967
3-11

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN Blackfoot
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN Blackfoot
061
d. STREET ADDRESS (If rural, give location) Route 3

3. NAME OF DECEASED (Type or Print)
a. (First) RAY
b. (Middle) J.
c. (Last) ESKELSEN

4. DATE OF DEATH (Month) (Day) (Year) October 16, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH October 13, 1896
9. AGE (In years last birthday) 71
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant 82
10b. KIND OF BUSINESS OR INDUSTRY Clothing
11. BIRTHPLACE (State or foreign country) Mink Creek, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Eskel Eskelsen
BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Minnie Christensen
BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) World War I 3
16. SOCIAL SECURITY NO. 518-09-0230
17. INFORMANT'S OWN SIGNATURE Ida L. Eskelsen
ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart disease — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death
1- Fractured rib multiple
2- Pneumothorax left
3- Severe contusion & hemorrhage buttock
4- Tracheotomy
5- Pulmonary contusion
6- Uremia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1952 *to* Oct 16, 1967, *that I last saw the deceased alive on* Oct 16, 1967, *and that death occurred at* 5:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Dean Packer 403 (Degree or title) M.D.
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED Oct 14, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 19, 1967
24c. NAME OF CEMETERY OR CREMATORY Riverside-Thomas cemetery
24d. LOCATION (City, town, or county) (State) Bingham county, Idaho

DATE REC'D BY LOCAL REG. Oct 18, 1967
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER Dean Hill
LICENSE NO. E-466
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 6 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 27 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4350
Local Reg. No. 321
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital (D.O.A.) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salt Lake City 555
d. STREET ADDRESS (If rural, give location): 2636 Dolphin Way

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Graham
c. (Last): Stidger

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1967

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 6, 1925
9. AGE (In years last birthday): 42 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Representative
10b. KIND OF BUSINESS OR INDUSTRY: Lighting 24
11. BIRTHPLACE (State or foreign country): Orange, New Jersey
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dr. Ivan Read Stidger — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Ethel Graham — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. II 4
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Salt Lake City, Ut

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerosis, severe, coronary arteries

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Myocardial infarct, multiple, old
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: T. Mitchell M.D. 746 (Degree or title): Pathologist
23b. ADDRESS: L.D.S. Hosp. Idaho Falls, Ida.
23c. DATE SIGNED: 10/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: Oct. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Aultorest Crematory
24d. LOCATION (City, town, or county) (State): Ogden, Utah

DATE REC'D BY LOCAL REG.: Oct. 30-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Bill Sullivan
LICENSE NO.: E 387

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 6 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

OCT 20 1967

Certificate of Death

STATE OF IDAHO

State File No. 4351
Local Reg. No. 127
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH — Bureau of Vital Statistics
a. COUNTY 061 Bingham 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot Rural
c. LENGTH OF STAY (in this place) 5 minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Interstate 15 So., Truchot Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Utah 45
b. COUNTY Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salt Lake City 555
d. STREET ADDRESS (If rural, give location) 4632 Brookwood Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Roy	Ellison	Goodman		Oct.	18,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	married 3	Feb. 10, 1926	41				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman 24	Keystone Readers	Salt Lake City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Roy Goodman	Utah	Ingry Larsen	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW II	528-24-5471	Mrs. Katherine Nelson	566 E. 6th South S.L. City, Utah

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed Head — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Car accident

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident	Interstate 15, South	7 miles South Blackfoot, Bingham, Idaho 060

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
10-18-67 10:35A.M.		

22. *I hereby certify that I attended the deceased from* Did not see him alive, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 10:35 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl Stone	Coroner	Blackfoot, Idaho	10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	10-19-67		Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
October 19, 1967	Dorothy J. Jones	Howard Packham	E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 1 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 1 1 1990

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4352
Local Reg. No. 129
Reg. Dist. No. 600

Certificate of Death

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham 1-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. Vital Statistics STAY (in this place) 3 yrs 6mo's.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Nursing Home 304

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen 060
d. STREET ADDRESS (If rural, give location) Aberdeen

3. NAME OF DECEASED (Type or Print)
a. (First) Nellie
b. (Middle) Grant
c. (Last) Weeks

4. DATE OF DEATH (Month) Oct. (Day) 22, (Year) 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Nov. 19, 1881
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months 11 Days 3 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Little Platte, Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Washington Wilson — BIRTHPLACE Shelbyville, Indiana
14. MOTHER'S MAIDEN NAME Eliza Jane Tarrell — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE James L. Warner — ADDRESS Aberdeen, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis 5 Yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1964, *to* 10-22, 1967, *that I last saw the deceased alive on* 10-20, 1967, *and that death occurred at* 3:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE J. M. Withers 569 (Degree or title) M.D.
23b. ADDRESS 625 West Pacific St. Blackfoot, Idaho
23c. DATE SIGNED 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-25-67
24c. NAME OF CEMETERY OR CREMATORY Aberdeen Cemetery
24d. LOCATION (City, town, or county) (State) Aberdeen, Bingham, Idaho

DATE REC'D BY LOCAL REG. Oct. 27, 1967
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER Howard Packham
LICENSE NO. E-338

Federal Security Agency
United States Public Health Service
Form OH-63021
FIRM NAME: Howard Packham Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 1 5 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4353
Local Reg. No. 730
Reg. Dist. No. 600

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham 1-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfot
DURATION OF STAY (in this place) 3 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Nursing Home 304

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot 061
d. STREET ADDRESS (If rural, give location) 251 Parson Street

3. NAME OF DECEASED (Type or Print) a. (First) Ann b. (Middle) Emily c. (Last) Jensen

4. DATE OF DEATH (Month) (Day) (Year) Oct. 23, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH May 17, 1889

9. AGE (In years last birthday) 78
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Layton, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas H. Findlay BIRTHPLACE Layton, Utah

14. MOTHER'S MAIDEN NAME Margaret E. Carpenter BIRTHPLACE Layton, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE K Laurel J. Jensen ADDRESS Blackfoot, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 493X Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus, arteriosclerosis — 10 years.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 25, 1961, *to* 23 Oct, 1967, *that I last saw the deceased alive on* 12 Oct, 1967, *and that death occurred at* 8:00A. m., *from the causes and on the date stated above.*

23a. SIGNATURE Walter M Hoge 234 (Degree or title) M.D. 1

23b. ADDRESS 53 Poplar Blackfoot, Idaho

23c. DATE SIGNED 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-26-67

24c. NAME OF CEMETERY OR CREMATORY Groveland Cemetery

24d. LOCATION (City, town, or county) (State) Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG. Oct 27, 1967

REGISTRAR'S SIGNATURE Dorothy L Jones

25. EMBALMER Howard Packham

LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4354
Local Reg. No. 135
Reg. Dist. No. 601

BIRTH NO.

RECEIVED NOV 20 1967 VITAL STATISTICS

1. PLACE OF DEATH
a. COUNTY 060 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sterling (Rural)
c. LENGTH OF STAY IN (this place) 404 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) American Falls reservoir 008

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moreland (Rural) 060
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) ARCHIE b. (Middle) E. c. (Last) BENNETT

4. DATE OF DEATH (Month) (Day) (Year) October 26, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH November 13, 1902

9. AGE (In years last birthday) 64 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 11

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Absorkie, Montana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nelson T. Bennett BIRTHPLACE Carthage, Ill.

14. MOTHER'S MAIDEN NAME Nora Barkdall BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) W.W. II 4

16. SOCIAL SECURITY NO. 518-10-8865

17. INFORMANT'S OWN SIGNATURE E. Bennett ADDRESS Moreland, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Exposure — INTERVAL BETWEEN ONSET AND DEATH 5 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Boat tipped over & became washed

DUE TO (c) exposed to 20° weather

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Snake River 18

21c. (CITY, TOWN, OR TOWNSHIP) 13 mile South Blackfoot (COUNTY) 060 Bingham (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 26 19 67, to ~~xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx~~ 19 ~~xx~~ *that I last saw the deceased alive on* ~~xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx~~, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Carl Stokes — 583 (Degree or title) Coroner 4

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED Oct 30, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct 30, 1967

24c. NAME OF CEMETERY OR CREMATORY Riverview cemetery

24d. LOCATION (City, town, or county) Firth, (State) Idaho

DATE REC'D BY LOCAL REG. 11-14-67

REGISTRAR'S SIGNATURE Dorothy J. James

25. EMBALMER C. Dean Hill — LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4355
Local Reg. No. 735
Reg. Dist. No. 600

BIRTH NO.

RECEIVED NOV 20 1967 VITAL STATISTICS

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 26 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 795 South University

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot 061
d. STREET ADDRESS (If rural, give location): 795 South University

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	ERNEST	SMEDLEY	October 28 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married 3	April 30, 1893	74		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Dentist 15	Dentist	Bountiful, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ernest W. Smedley	Utah	May Barlow	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-14-9706	Mrs N E. Smedley	Blackfoot, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Myocardial Infarction	hours
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 28 Oct, 19 67, *to* October 28 19 67, *that I last saw the deceased alive on* October 28 19 67, *and that death occurred at* 11 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. Miller Jr 361	M.D.	Blackfoot, Idaho	Oct 31,67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct 31,67	Grove City Cemetery	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 14, 1967	Dorothy J. Jones	C. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4356
Local Reg. No. 731
Reg. Dist. No. 601

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 061 Bingham 154
b. CITY OR TOWN Blackfoot Rural
c. LENGTH OF STAY (in this place) 54 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Route #4 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN Rural Blackfoot 061
d. STREET ADDRESS (If rural, give location) Rt. #4

3. NAME OF DECEASED (Type or Print): a. (First) Ella b. (Middle) c. (Last) Going

4. DATE OF DEATH (Month) (Day) (Year): Oct. 28, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: July 14, 1894

9. AGE (In years last birthday): 73 | IF UNDER 1 YEAR Months: 3 | Days: 14 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Dingle, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel Humpherys BIRTHPLACE: Mansfield, England

14. MOTHER'S MAIDEN NAME: Hannah Martha Clifton BIRTHPLACE: Paris, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-10-1876B

17. INFORMANT'S OWN SIGNATURE: Lelande B Going ADDRESS: Rt. #4, Blf't.Ida.

4201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Recent surgery for malignancy of bowel. 6 mo & broken Stroke paralysis left leg

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Approx. 1948, *to* Oct 28, 1967, *that I last saw the deceased alive on* Oct. 21, 1967, *and that death occurred at* 2:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 404 (Degree or title) M.D.

23b. ADDRESS: Blackfoot, Idaho 625 West Pacific

23c. DATE SIGNED: 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-31-67

24c. NAME OF CEMETERY OR CREMATORY: Moreland Cemetery

24d. LOCATION (City, town, or county) (State): Moreland, Bingham, Idaho

DATE REC'D BY LOCAL REG.: Nov. 2, 1967

REGISTRAR'S SIGNATURE: Dorothy G. James

25. EMBALMER: Howard Packham LICENSE NO.: E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form UH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4357
Local Reg. No. 46
Reg. Dist. No. 410

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 070 OCT 11 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics): Sun Valley
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ketchum 070
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Miles
b. (Middle):
c. (Last): Nance

4. DATE OF DEATH (Month) (Day) (Year): Oct. 4, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 9, 1920
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Butcher 21
10b. KIND OF BUSINESS OR INDUSTRY: Meat
11. BIRTHPLACE (State or foreign country): Green Forest, Arkansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William A. Nance — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II 8
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Zeta Nance — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: at least 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8-17-67
19b. MAJOR FINDINGS OF OPERATION: Negative Exploration of pbdenne
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/9, 1967, *to* 10-4, 1967, *that I last saw the deceased alive on* 10-4, 1967 *and that death occurred at* 1:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] M.D. 752 (Degree or title)
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: 10-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Ketchum Cemetery
24d. LOCATION (City, town, or county) (State): Ketchum Idaho

DATE REC'D BY LOCAL REG.: Oct 9-1967
REGISTRAR'S SIGNATURE: Robert H. Wright per CBW
25. EMBALMER: Keith Bird [signature]
LICENSE NO.: E373
FIRM NAME: Bird Funeral Home Hailey Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4358
Local Reg. No. 215
Reg. Dist. No. 410

BIRTH NO.

OCT 11 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 070 Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Carey
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Carey 070
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Myrtle b. (Middle) L. c. (Last) Axford

4. DATE OF DEATH (Month) (Day) (Year) Oct. 4, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH March 1, 1906

9. AGE (In years last birthday) 61 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office 19

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Bellevue, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John H. Little BIRTHPLACE Buffalo N. Y.

14. MOTHER'S MAIDEN NAME Minnie E Ralls BIRTHPLACE Missouri Kirksville Co.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Bessie Stanford ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction, hospital

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic heart

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH 1 yr.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 ____, 19 66, *to* 9-29 ____, 19 67, *that I last saw the deceased alive on* 9-29 ____, 19 67 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Mark Peterson 752 (Degree or title)

23b. ADDRESS Sun Valley Idaho

23c. DATE SIGNED 10-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 6, 1967

24c. NAME OF CEMETERY OR CREMATORY Bellevue Cemetery

24d. LOCATION (City, town, or county) (State) Bellevue Idaho

DATE REC'D BY LOCAL REG. Oct 9-1967

REGISTRAR'S SIGNATURE Robert H. Wright

25. EMBALMER Keith Bird Keith Bird

LICENSE NO. E 373

FIRM NAME Bird Funeral Home Hailey Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021 per 6/37W

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4359
Local Reg. No. 48
Reg. Dist. No. 410

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 30 1967

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey 070
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Richard
b. (Middle): Wayne
c. (Last): Dugger

4. DATE OF DEATH (Month) (Day) (Year): Oct. 15, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: Jan. 28, 1950
9. AGE (In years last birthday): 17 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sun Valley, Idaho
12. CITIZEN OF WHAT COUNTRY?: Usa

13. FATHER'S NAME: Robert Dugger — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Wilma Davis — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-62-4197
17. INFORMANT'S OWN SIGNATURE: Robert W. Dugger — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8224

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Massive cerebral trauma — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): South of Ketchum 070 Blaine Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 15 67 1a.00 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Auto overturned

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Rhea H. Earle MD Coroner 583 (Degree or title) 4
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: 10/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 4
24b. DATE: Oct. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hailey Cemetery
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: Oct. 28/67
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird — Keith Bird
LICENSE NO.: E 373

Federal Security Agency
United States Public Health Service

Form DH-63021 per CBN

FIRM NAME: Bird Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: OCT 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4360
Local Reg. No. 22
Reg. Dist. No. 511-602

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 060	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. COUNTY Bingham	a. STATE Idaho b. COUNTY Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen	c. LENGTH OF STAY (in this place) 000
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 060 Aberdeen	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home (S W of Aberdeen) 000	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First) ANNA	b. (Middle) TOEVS	c. (Last) WENGER	4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 1967
5. SEX Female	6. COLOR OR RACE White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3	8. DATE OF BIRTH Oct. 5, 1889	9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months 0 Days 12 — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01	10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Newton, Kansas	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Toevs	BIRTHPLACE Danzig, Germany	14. MOTHER'S MAIDEN NAME Agatha Suderman	BIRTHPLACE South Russia	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 519-40-7958B	17. INFORMANT'S OWN SIGNATURE X Frank L. Wenger	ADDRESS Aberdeen, Idaho	

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral vascular accident	1 hour
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Old cerebral vascular accident	5 years
	Old myocardial infarction	5 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 12, 1962, *to* Oct. 17, 1967, *that I last saw the deceased alive on* Sep 15, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE J H Anderson MD 009 (Degree or title)	23b. ADDRESS Pocatello, Idaho	23c. DATE SIGNED 20 Oct 67
24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial 3 — 24b. DATE 10-19-67	24c. NAME OF CEMETERY OR CREMATORY Homestead Cemetery	24d. LOCATION (City, town, or county) (State) Aberdeen, Idaho
DATE REC'D BY LOCAL REG. 10-24-67 — REGISTRAR'S SIGNATURE Colleen Godfried	25. EMBALMER H. L. Davis	LICENSE NO. E-253

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4361
Local Reg. No. 49
Reg. Dist. No. 410

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 30 1967
Bureau of Vital Stat

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Carey 070
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): G.
b. (Middle): Milford
c. (Last): Sparks

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 31, 1895
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Dingle, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Sparks — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Harriet Esterholdt — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: [signature] D. Sparks — ADDRESS: 2881 South 150E Bountiful, Utah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 17 Oct, 1967, *to* 18 Oct, 1967, *that I last saw the deceased alive on* 18 Oct, 1967, *and that death occurred at* 9 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 151 MD
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: 10/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Carey Cemetery
24d. LOCATION (City, town, or county) (State): Carey, Idaho

DATE REC'D BY LOCAL REG.: Oct. 28/67
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird [signature] Keith Bird
LICENSE NO.: E373

Federal Security Agency
United States Public Health Service

Form DH-6302 per C.B.H.

FIRM NAME: Bird Fumeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 27 1984

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4362
Local Reg. No. 50
Reg. Dist. No. 410

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

1. PLACE OF DEATH
a. COUNTY: Blaine 070 OCT 30 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Carey Bureau of Vital Stat
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Carey 070
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Mellie
b. (Middle): Sophia
c. (Last): Parke

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 25, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dingle, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Sparks — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Harriet Esterholdt — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-34-5444
17. INFORMANT'S OWN SIGNATURE: Curtis Parke — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary infarction (presumed) — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Alex H Earle Mrs 583 Coroner
23b. ADDRESS: 4 Sun Valley, Idaho
23c. DATE SIGNED: 10/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Carey Cemetery
24d. LOCATION (City, town, or county) (State): Carey, Idaho

DATE REC'D BY LOCAL REG.: Oct 28/67
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird Keith Bird
LICENSE NO.: E373

Federal Security Agency
United States Public Health Service
Form DH-63020 Rev 6 B.W.
FIRM NAME: Bird Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 31 1967

MAR 27 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4363
Local Reg. No. 51
Reg. Dist. No. 410

BIRTH NO.

NOV 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ketchum
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ketchum 070
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Candido
b. (Middle):
c. (Last): Batis

4. DATE OF DEATH (Month) (Day) (Year): Oct. 30, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Oct. 3, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborur 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Frunis Spain
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Batis — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Paula Legarrita — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Tomas Batis — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CIRRHOSIS OF LIVER
ANTECEDENT CAUSES — CHRONIC RENAL DISEASE
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) GENERALIZED ARTEMOSCLEROSIS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-11, 1967, *to* 10-30, 1967, *that I last saw the deceased alive on* 10-11, 1967, *and that death occurred at* 6:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marcus Petersen MD 1752
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 3, 67
24c. NAME OF CEMETERY OR CREMATORY: Ketchum Cemetery
24d. LOCATION (City, town, or county) (State): Ketchum Idaho

DATE REC'D BY LOCAL REG.: Nov. 9-1967
REGISTRAR'S SIGNATURE: Robert H. Wright per [illegible]
25. EMBALMER: Keith Bird
LICENSE NO.: E 373

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bird Funeral Home, Hailey, Idaho

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 15 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 27 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 14 1986

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4364
Local Reg. No. 119
Reg. Dist. No. 110

RECEIVED Bureau of Vital Statistics OCT 24 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ponderay 090
d. STREET ADDRESS (If rural, give location): Inside village limits

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Isam	David	Russell	October 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	June 6, 1879	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Cattle & sheep	Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William R. Russell	Missouri	Cyntha Ann Tobey	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	--	519-60-4888	Kyle Russell	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4438 Sudden death / Ventricular fibrillation — INTERVAL BETWEEN ONSET AND DEATH: Several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes — 3 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Dec 9, 1959, *to* Oct 6, 1967, *that I last saw the deceased alive on* Oct 5, 1967, *and that death occurred at* 5:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Leroy Duncan MD		Kentucky Ave	10/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 9, 1967	Pinecrest Cemetery	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 23, 1967	Fayden G. Tibbetts	Dale G. Coffelt	E-501

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Moon Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4365
Local Reg. No. 116
Reg. Dist. No. 110

RECEIVED OCT 16 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 090
a. COUNTY Bonner 4-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Camp Bay
c. LENGTH OF STAY (in this place) 2 Hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lake Pend Oreille 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Washington 48
b. COUNTY Whitman 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pullman
d. STREET ADDRESS (If rural, give location) 100 West Windus

3. NAME OF DECEASED (Type or Print)
a. (First) Lloyd
b. (Middle) E.
c. (Last) Rogers

4. DATE OF DEATH (Month) (Day) (Year) Oct. 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 11, 1905
9. AGE (In years last birthday) 62 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) T.V. Technician 22
10b. KIND OF BUSINESS OR INDUSTRY owner
11. BIRTHPLACE (State or foreign country) Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas H. Rogers BIRTHPLACE Cottage Grove, Ore.
14. MOTHER'S MAIDEN NAME Ladessa E. Tritt BIRTHPLACE Manhattan, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 533-10-4391
17. INFORMANT'S OWN SIGNATURE x Mrs Lloyd E Rogers ADDRESS Pullman, Wn.

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 2:15 P.m., from the causes and on the date stated above.*

23a. SIGNATURE Danny D. Nelson 583 Coroner (Degree or title) 4
23b. ADDRESS Sandpoint, Idaho 83864
23c. DATE SIGNED 10/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery
24d. LOCATION (City, town, or county) (State) Moscow, Idaho

DATE REC'D BY LOCAL REG. Oct. 13, 1967
REGISTRAR'S SIGNATURE Phyllis Y. Tibbetts
25. EMBALMER L. G. Moon Jr. LICENSE NO. E405

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4366
Local Reg. No. 120
Reg. Dist. No. 110

RECEIVED

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonner 091 — OCT 24 1967 — 3-13
b. CITY OR TOWN: Sandpoint
c. LENGTH OF STAY IN THIS PLACE: 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): Rt. 2, Box 229

3. NAME OF DECEASED (Type or Print): a. (First) Sarah — b. (Middle) Ellen — c. (Last) Burns

4. DATE OF DEATH: (Month) (Day) (Year): October 9, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 23, 1892
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Donaldson — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Anna Donaldson — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 517-10-3797D
17. INFORMANT'S OWN SIGNATURE: x Annabelle Riffle — ADDRESS: Rte #2 Sandpoint, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): acute Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Anemia - Iron Deficiency - Intestinal Carcinoma

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 19, 1967, *to* Oct 9, 1967, *that I last saw the deceased alive on* Oct 9, 1967, *and that death occurred at* 11:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 471 (Degree or title) MD
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: Oct 16, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Denton Cemetery
24d. LOCATION (City, town, or county) (State): Denton, Montana

DATE REC'D BY LOCAL REG.: Oct 23, 1967
REGISTRAR'S SIGNATURE: Faylis G. Tibbetts
25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501
FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4367
Local Reg. No. 121
Reg. Dist. No. 110

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091 NOV 6 1967 4-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint Bureau of Vital Statistics
c. LENGTH OF STAY (Hours in this place): 5 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana 27
b. COUNTY: Sanders
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Trout Creek 555
d. STREET ADDRESS (If rural, give location): P. O. Box 1373

3. NAME OF DECEASED (Type or Print)
a. (First): Darlene
b. (Middle): Nina
c. (Last): Hill

4. DATE OF DEATH (Month) (Day) (Year): October 10, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 1, 1952
9. AGE (In years last birthday): 15 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: School
11. BIRTHPLACE (State or foreign country): Montana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clarence A. Rogers — BIRTHPLACE: North Dakota
14. MOTHER'S MAIDEN NAME: Mary I. Potter — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Mrs. Clarence Rogers — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8164 Cerebral Contusion — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Auto accident — 8 hours
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Extensive laceration of scalp 8 hours; Fr. Rt. clavicle 8 hours

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hwy 95 near Granite 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Bonner Idaho 090
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-10-67 45 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2
21f. HOW DID INJURY OCCUR?: Head on - auto accident

22. *I hereby certify that I attended the deceased from* 4 50 p 1967, *to* Oct 10, 1967, *that I last saw the deceased alive on* Oct 10, 1967 *and that death occurred at* 11 45 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John W. Smith 480 MD
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 10-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial - Removal
24b. DATE: Oct. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Noxon Cemetery
24d. LOCATION (City, town, or county) (State): Noxon Montana

DATE REC'D BY LOCAL REG.: Oct. 31, 1967
REGISTRAR'S SIGNATURE: Charles G. Tibbetts
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 5 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4368
Local Reg. No. 11 8
Reg. Dist. No. 110

BIRTH NO.

RECEIVED

1. PLACE OF DEATH
a. COUNTY Bonner 090 OCT 24 1967 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Granite Hill Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Highway 95 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY San Diego
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lemon Grove 555
d. STREET ADDRESS (If rural, give location) 2568 Mulder Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Thelma	Lee	Mulder	October 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	March 26, 1905	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Owen Humphrees	Kentucky	Willie	No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	--	No record	V L W Mulder	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8164

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive accidental Trauma — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Fractures and hemorhage, multiple and extreme

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Highway 95 06	Granite Hill 13	Bonner 090	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
10/10/67 4 p.m. 2		Auto accident; head-on collision

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Darrel D Nelson 583	Coroner	Sandpoint, Idaho	10/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct. 12, 1967	Greenwood Mortuary	San Diego, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 16, 1967	Cynthia G. Tibbetts	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 25 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 27 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 5 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4369
Local Reg. No. 122
Reg. Dist. No. 110

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonner 091 424
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 1/2 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint 091
d. STREET ADDRESS (If rural, give location): 317 Cedar Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Burton	F.	Reynolds	Oct. 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	May 20, 1922	45				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Invalid 28	Invalid	Sidney, Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Reynolds	Iowa	Lula Pooley	South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	--	535-20-5186	Loyal G. Reynolds	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: Weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute alcoholism — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

3220

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Danny O Nelson 583	Sandpoint, Idaho	10/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 21, 1967	Pinecrest Cemetery	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 31, 1967	Phyllis G. Willcutts	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4370
Local Reg. No. 125
Reg. Dist. No. 110

RECEIVED
NOV 16 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (In this place): 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint 091
d. STREET ADDRESS (If rural, give location): 521 Olive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Daniel	George	Massing	October 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	August 3, 1918	49		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Staff Man - U.S.D.A.,
10b. KIND OF BUSINESS OR INDUSTRY: 08 U. S. Forest Service
11. BIRTHPLACE (State or foreign country): Montana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Massing	New York	Erma L. C. Mull	Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. II 4
16. SOCIAL SECURITY NO.: 516-22-7729
17. INFORMANT'S OWN SIGNATURE: Margaret R. Massing ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 9744 Suffocation — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Strangulation

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Suicide 2	Residence 01	Sandpoint 13	Bonner 09	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 28, 1967 1:30PM
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2
21f. HOW DID INJURY OCCUR? Self inflicted hanging

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Barry D. Nelson 583	Coroner	Sandpoint, Idaho	10/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation 2	Oct. 31, 1967	Moon Crematory	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 6, 1967	Langdon G. Willett	Dale G. Coffelt	E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 12 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4371
Local Reg. No. 512
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 2 1967 1-16 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF (If not in this place): 16 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 298 S. Capital Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Louis
b. (Middle): ALEXANDER
c. (Last): KEMMIS

4. DATE OF DEATH (Month) (Day) (Year): September 29, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 3, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heavy equipment operator
10b. KIND OF BUSINESS OR INDUSTRY: // Construction
11. BIRTHPLACE (State or foreign country): Sidney, Montana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter E. Kemmis — BIRTHPLACE: Ireland
14. MOTHER'S MAIDEN NAME: Hannah Wills — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 201-03-2265
17. INFORMANT'S OWN SIGNATURE: John A. Elliott — ADDRESS: Ida. Idaho Falls,

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-7-1962 *to* 9-29, 1967, *that I last saw the deceased alive on* 9-29, 1967, *and that death occurred at* 4:20P *m., from the causes and on the date stated above.*

23a. SIGNATURE: John S. McMullen 348 (Degree or title): M.D. 1
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: October 3,67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct 2 1967
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Orland C. Buck
LICENSE NO.: E-250

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4372
Local Reg. No. 303
Reg. Dist. No. 610

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 101
a. COUNTY Bonneville OCT 18 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (If not in place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenview Rest Home 308

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneeville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls 101
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Ella Caroline b. (Middle) Schuldt c. (Last) Klamme

4. DATE OF DEATH (Month) (Day) (Year) Oct 1, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 24 May 1891
9. AGE (In years last birthday) 76 | IF UNDER 1 YEAR Months 4 Days 7 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Sioux County, Iowa
12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME Carl Schuldt BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Bertha Pieper BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Leona Larsen ADDRESS Idaho Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Generalized arteriosclerosis
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg. etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1, 1967, *to* Oct 1, 1967, *that I last saw the deceased alive on* Oct 1, 1967, *and that death occurred at* 2:10 pm *m., from the causes and on the date stated above.*

23a. SIGNATURE A. Mc Brum Jr M.D. 633 (Degree or title)
23b. ADDRESS Idaho Falls Idaho
23c. DATE SIGNED 10-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 4, 1967
24c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. Oct. 10-1967
REGISTRAR'S SIGNATURE Anna Bridger
25. EMBALMER Leo A Williams
LICENSE NO. E-319

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 19 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4373
Local Reg. No. 301
Reg. Dist. No. 670

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 3-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 736 John Adams Parkway

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Fred	J. A.	Gruel	October 1 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	November 11, 1888	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Manager 26	Mfg. Company	Chicago, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Gruel	USA	Caroline	USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WW 1 3	372 10 0808	Fred J. Gruel	Idaho Falls, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c) Age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-22- , 1967, *to* October 1, 1967, *that I last saw the deceased alive on* October 1, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Milton T. Koos M.D.		148 N. Corner Ave, Idaho Falls	10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10/4/67	Grand Lawn Cemetery	Detroit Michigan

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 12-1967	Emma Budge	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to --

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH --

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Herb

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4374
Local Reg. No. 364
Reg. Dist. No. 610

BIRTH NO.

OCT 23 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Valeria b. (Middle) Sarah c. (Last) (Sadie) Winmill

4. DATE OF DEATH (Month) (Day) (Year): October 3 1967

5. SEX: famale

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: 25 Oct. 1888

9. AGE (In years last birthday): 78 | IF UNDER 1 YEAR Months: 1 Days: 8 | IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mountain Del, Saltlake Co., Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richard Winmill — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Elizabeth Baird — BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Viola M. Belnap — ADDRESS: Idaho Falls Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 332X Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July, 1963, *to* Oct 3, 1967, *that I last saw the deceased alive on* Oct 2, 1967, *and that death occurred at* 4:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Byron T Wells — (Degree or title): 336 MD — **23b. ADDRESS**: 1585 So. Boulevard — **23c. DATE SIGNED**: 10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem & Bur 3

24b. DATE: Oct. 5, 1967

24c. NAME OF CEMETERY OR CREMATORY: Sugar City Cemetery

24d. LOCATION (City, town, or county) (State): Sugar City, Idaho

DATE REC'D BY LOCAL REG.: Oct. 16-1967

REGISTRAR'S SIGNATURE: Anna Rudges

25. EMBALMER: Leo R Williams — **LICENSE NO.**: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-6453

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4375
Local Reg. No. 305
Reg. Dist. No. 610

BIRTH NO.

OCT 18 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place) 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1452 Terry 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101 b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1452 Terry

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Tammy	Lynn	Larson	October 4 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	July 9, 1967		2	25		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
None 02	None	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Merrill Larson	Idaho	Carol Jane Larch	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	James M. Larson	Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7954

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) SUDDEN UNEXPECTED DEATH (CRIB DEATH)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) SECONDARY TO ELECTROLYTE IMBALANCE

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ASPIRATION, TERMINAL

INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
NONE		IDAHO FALLS BONNEVILLE IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hazel L. McCaffey M.D. 583 HAZEL L. MC CAFFEY, M.D. CORONER	2525 SOUTH BOULEVARD, IDAHO FALLS	10/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/6/67	Fielding Memorial Park	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 16-1967	Anna Bridges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician 3 MONTH OLD INFANT FOUND DEAD IN CRIB AT 6:00 AM IN THE MORNING; APPARENTLY DEAD FOR 5-7 HOURS.

H. L. McGaffey M. D.

H. L. McGAFFEY, M. D.

State File No. 4376
Local Reg. No. 308
Reg. Dist. No. 610

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 20 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 100 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Irwin
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Margaret
b. (Middle):
c. (Last): Cole

4. DATE OF DEATH (Month) (Day) (Year): October 5 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: December 14, 1897
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Vernal, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Q. Murray — BIRTHPLACE: USA
14. MOTHER'S MAIDEN NAME: Charlotte Jeanette Searle — BIRTHPLACE: Nevada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Francis Albert Cole — ADDRESS: Irwin, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Vascular Accident — 3 weeks
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Bronchial Asthma + Obesity — several years.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: none
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 Sept, 1967, *to* 5 Oct, 1967, *that I last saw the deceased alive on* 5 Oct, 1967, *and that death occurred at* 10:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Goddard Arp 503
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 16 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/9/67
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county): Idaho Falls — (State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 18-67
REGISTRAR'S SIGNATURE: Anna Bredgen
25. EMBALMER: Ralph M. Wood — Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4377
Local Reg. No. 277
Reg. Dist. No. 610

RECEIVED
NOV 2 1967
Bureau of Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE 10 205
b. CITY OR TOWN: IDAHO FALLS
c. LENGTH OF STAY IN (this place): 5 MO.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SACRED HEART HOSPITAL 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 42
b. COUNTY: TWIN FALLS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): TWIN FALLS
d. STREET ADDRESS (If rural, give location): 1608 9th AVE SOUTH

3. NAME OF DECEASED (Type or Print): a. (First) HUGH b. (Middle) A c. (Last) BAKER

4. DATE OF DEATH: (Month) OCT. (Day) 5, (Year) 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2

8. DATE OF BIRTH: OCT. 21, 1888

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LAWYER 16

10b. KIND OF BUSINESS OR INDUSTRY: DIST. JUDGE

11. BIRTHPLACE (State or foreign country): APPANOOSE CO. IOWA

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ALBERT H. BAKER BIRTHPLACE: Appanoose Co., Iowa

14. MOTHER'S MAIDEN NAME: SARAH E. STARK BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 720-03-4216A

17. INFORMANT'S OWN SIGNATURE: Jane B. St. Clair ADDRESS: Ida. Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Appros 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 28, 19 67, *to* Oct. 5, 19 67, *that I last saw the deceased alive on* Oct. 5, 19 67 *and that death occurred at* 6:05A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. K. Krantz M.D.

23b. ADDRESS: 798 South Blvd. Idaho Falls, Idaho

23c. DATE SIGNED: 10/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

24b. DATE: 10/7/67

24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery

24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: Oct 21, 1967

REGISTRAR'S SIGNATURE: Anna Rodgers

25. EMBALMER: Buck Sullivan LICENSE NO.: E387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4378
Local Reg. No. 278
Reg. Dist. No. 610

Certificate of Death

RECEIVED
NOV 2 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE 107
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
c. LENGTH OF STAY (If hospital place): 7YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SACRED HEART HOSPITAL 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 107
b. COUNTY: BONNEVILEE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 635 8th. STREET
d. STREET ADDRESS (If rural, give location): IDAHO FALLS, IDAHO

3. NAME OF DECEASED (Type or Print)
a. (First): WALTER
b. (Middle): HARLAN
c. (Last): BERGMAN

4. DATE OF DEATH (Month) (Day) (Year): Oct. 5, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: MAY 15, 1926
9. AGE (In years last birthday): 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): PHARMACIST 21
10b. KIND OF BUSINESS OR INDUSTRY: PHARMACY
11. BIRTHPLACE (State or foreign country): TACOMA, WASHINGTON
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: FRANK W. BERGMAN — BIRTHPLACE: SIOUX CITY, IOWA
14. MOTHER'S MAIDEN NAME: MAXINE MILLER — BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW II — (If yes, give war or dates of service): WWII 4
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Patricia T. Bergman — ADDRESS: 635 8th St. Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Thrombosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1963, *to* Oct 5, 1967, *that I last saw the deceased alive on* Oct 5, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Byron T. Weeks MD 556
23b. ADDRESS: 1585 S. Boulevard
23c. DATE SIGNED: Oct 16, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct. 10, 67
24c. NAME OF CEMETERY OR CREMATORY: Custer Natl. Mont.
24d. LOCATION (City, town, or county) (State): Crow Agency, Montana

DATE REC'D BY LOCAL REG.: Oct. 21-'67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Bill Sullivan — LICENSE NO. E387
FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

HJ Hatch

Certificate of Death

STATE OF IDAHO

State File No. 4379
Local Reg. No. 306
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Bonneville 101 003

b. CITY OR TOWN (If outside corporate limits, write township): Idaho Falls

LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 101 b. COUNTY: Bonneville

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

d. STREET ADDRESS (If rural, give location): 956 Wheeler

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WALTER		SCHMOCKER	6 Oct. 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
malw	white	Widowed 2	1 Dec. 1901	65	10	5		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mett Switzerland

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Friedrich Schmocker BIRTHPLACE: Switzerland

14. MOTHER'S MAIDEN NAME: Jda Deuret BIRTHPLACE: Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Erdmann Schmocker ADDRESS:

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis, generalized — 4 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* 6 Oct., 1967, *and that death occurred at* 3:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harvey A. Hatch	208 M.D.	Idaho Falls, Idaho	9 Oct. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10 Oct. 1967	Rosehill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 16-1967	Lenore Bridger	Leo A Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 3 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 23 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4380
Local Reg. No. 309
Reg. Dist. No. 6

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN Idaho Falls (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Highway #91

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 496 Oneida St.

3. NAME OF DECEASED (Type or Print)
a. (First) George
b. (Middle)
c. (Last) Musgrave

4. DATE OF DEATH (Month) (Day) (Year) Oct 7, 1967

5. SEX male

6. COLOR OR RACE whiite

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH 5 Jan. 1941

9. AGE (In years last birthday) 26
IF UNDER 1 YEAR: Months 9, Days 2
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 21

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Thomas Musgrave
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Violet Sarah Walker
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE W A Bagshaw
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) STEERING WHEEL CRUSH INJURY TO CHEST & TRUMA TO HEAD

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) SINGLE CAR AUTOMOBILE ACCIDENT

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. BLOOD ALCOHOL ELEVATED TO 2.2 MG/CC

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) ACCIDENT

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) IDAHO FALLS (COUNTY) BONNEVILLE (STATE) IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Hazel L. McGaffey
HAZEL L. MC GAFFEY, M. D.

(Degree or Title) CORONER

23b. ADDRESS 2525 SOUTH BOULEVARD, IDAHO FALLS

23c. DATE SIGNED 10/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10 Oct. 1967

24c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery

24d. LOCATION (City, town, or county) Idaho Falls, Idaho (State)

DATE REC'D BY LOCAL REG. Oct 18-1967

REGISTRAR'S SIGNATURE Emma Rudgen

25. EMBALMER Leo A Williams

LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 19 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. John

Certificate of Death

State File No. 4381
Local Reg. No. 319
Reg. Dist. No. 616

BIRTH NO.

RECEIVED STATE OF IDAHO

NOV 2 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 14 Illinois
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Newman, Illinois
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): EARL
b. (Middle): O.
c. (Last): SWICKARD

4. DATE OF DEATH (Month) (Day) (Year): Oct 7, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: 26, Nov 1893
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months 10, Days 11 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Westfield, Illinois
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: William Swickard — BIRTHPLACE: ? U.S.A.
14. MOTHER'S MAIDEN NAME: Iola Hardinger — BIRTHPLACE: ? U.S.A.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Henrietta Dyer — ADDRESS: Idaho Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

177X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer of prostate with

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Metastasis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH: 6 months

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 6-1-, 1967, *to* 10-7-, 1967, *that I last saw the deceased alive on* 9-30-, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] S Hater 210 M.D.
23b. ADDRESS: 1050 Memorial Dr. Idaho Falls Idaho
23c. DATE SIGNED: 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): NRem & Burial 3
24b. DATE: Oct 9-1967
24c. NAME OF CEMETERY OR CREMATORY: Fairfield Cemetery
24d. LOCATION (City, town, or county) (State): Newman, Illinois

DATE REC'D BY LOCAL REG.: Oct. 28-1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Leo A Williams
LICENSE NO.: E-319

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 3 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 15 1977

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

APR 0 9 1996

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4382
Local Reg. No. 378
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 10 Bonneville 306
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 34
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 341 E. 3rd St. North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	William	Rainsford	Taylor	Oct. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	April 9, 1905	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Manager C.W.P. 26	Produce Plant	Unknown	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles E. Taylor	Canada	Pauline Smith	Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	004-07-5991	Blanche M. Taylor	Burley, Ida.

18. CAUSE OF DEATH 332X

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral infarction — INTERVAL BETWEEN ONSET AND DEATH: 25 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES XXX NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct. 2, 19 67, *to* Oct. 7, 19 67, *that I last saw the deceased alive on* Oct. 7, 19 67, *and that death occurred at* 9:10 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
294 L. K. Frantz M.D.	798 South Blvd. Idaho Falls, Idaho	Oct. 17, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10/7/67	Gem Memorial Gardens	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 18-67	Emma Bridges	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4383
Local Reg. No. 307
Reg. Dist. No. 610

RECEIVED OCT 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 301
b. CITY OR TOWN (If outside corporate limits, write township): Idaho Falls
DURATION OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 366 Gladstone

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Edward	St. Pierre	Bala	October	9	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	January 22, 1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Fort Douglas, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Pierre Bala	France	Margaret Jane Middlemiss	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 30 7180A	Elsie Bala	Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-29, 1959, *to* 10-9, 1967, *that I last saw the deceased alive on* 10-1, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John MacMillan 348 MD	520 Fourth St.	10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/11/67	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 16-1967	Anna Budge	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-630 2

OCT 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4384
Local Reg. No. 311
Reg. Dist. No. 610

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 231 Hill 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 231 Hill

3. NAME OF DECEASED (Type or Print)
a. (First): LaVon
b. (Middle): Viola
c. (Last): Frandsen

4. DATE OF DEATH (Month) (Day) (Year): October 11 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: February 11, 1913
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Lyman, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Sharp — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Lydia Millgate — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 28 3181
17. INFORMANT'S OWN SIGNATURE: Wilford C. Frandsen — ADDRESS: Idaho Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

287X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: Weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Obesity (345 lbs) — Years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1951, *to* 11 Oct, 1967, *that I last saw the deceased alive on* 11 Oct, 1967, *and that death occurred at* 11 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph M. Arthur MD 211
23b. ADDRESS: Idaho Falls Idaho
23c. DATE SIGNED: 16 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/14/67
24c. NAME OF CEMETERY OR CREMATORY: Iona Cemetery
24d. LOCATION (City, town, or county): Iona (State): Idaho

DATE REC'D BY LOCAL REG.: Oct 18-67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood — LICENSE NO.: 413

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 5 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 2 1967 Bureau of Vital Statistics

State File No. 4385
Local Reg. No. 575
Reg. Dist. No. 610

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls.
STAY (in this place): 3dys
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 060
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Goshen
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Emily b. (Middle) c. (Last) Heaton

4. DATE OF DEATH: (Month) Oct (Day) 11 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 22 Jan 1893

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 1 HR.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Mantua Utah

12. CITIZEN OF WHAT COUNTRY: USA.

13. FATHER'S NAME: Niels Christian Nelsen
BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Martha Jensen
BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Auril Heaton Christensen
ADDRESS: Shelley

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4200 Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes — Years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 5-31-, 1967, *to* 10-11, 1967, *that I last saw the deceased alive on* 10-11, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 546 (Degree or title) MD
23b. ADDRESS: Idaho Falls Ida
23c. DATE SIGNED: 10/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 14 1967
24c. NAME OF CEMETERY OR CREMATORY: Firth
24d. LOCATION (City, town, or county) (State): Firth, Bingham Idaho

DATE REC'D BY LOCAL REG.: Oct. 24 - 67
REGISTRAR'S SIGNATURE: Emma Bulgin
25. EMBALMER: L. M. Nalder
LICENSE NO.: E-275

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Nalder Funeral Home

FEB 14 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 9386
Local Reg. No. 316
Reg. Dist. No. 610

RECEIVED NOV 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 060
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley, Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Peter		Olson	Oct	11	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	30 Dec 1881	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farming
10b. KIND OF BUSINESS OR INDUSTRY 04 Farming
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Olof Perlson — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Anna Olsson — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-28-3304
17. INFORMANT'S OWN SIGNATURE Reg P Olson — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
(b) Pneumonia
DUE TO (b) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1960, *to* Oct 11, 1967, *that I last saw the deceased alive on* Oct 11, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Milton T. Rees 433 M.D.	Idaho Falls, Ida	10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-14-67	HillCrest	Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 24-1967	Anna Rudgin	L. M. Nader	E275

FIRM NAME: Nader Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4387
Local Reg. No. 314
Reg. Dist. No. 610

RECEIVED
NOV 2 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 10 / Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 241 First St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Mildred	Madison	Hendrickson	Oct. 12th 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	15 July 1900	67	2	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Idaho Falls, Idaho	USA.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Louis Madison	Denmark	Zina Christensen	Hyrum, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Mrs. Marjorie Thomas	

18. CAUSE OF DEATH 4200

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	CARDIAC ARREST DURING SLEEP	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	ARTERIOSCLEROTIC HEART DISEASE	UNKNOWN
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
NONE		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Physician or Coroner)	23b. ADDRESS	23c. DATE SIGNED
Hazel L. McGaffey HAZEL L. MC GAFFEY, M. D. CORONER	IDAHO FALLS, IDAHO 42525 SOUTH BOULEVARD AVE	10/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 17, 1967	Rosehill cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 26-1967	Anna Bridges	Leo A Williams	E 319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 21 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4388
Local Reg. No. 317
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 2 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 — 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 131 West 18th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Gladys
b. (Middle): Pack
c. (Last): Phillips

4. DATE OF DEATH (Month) (Day) (Year): Oct. 15 1967

5. SEX: famale
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 8 Dec. 1903
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months 10, Days 7 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kamas, Utah
12. CITIZEN OF WHAT COUNTRY?: USQ.

13. FATHER'S NAME: Rufus Pack Sr. — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Mary Tolbert — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Mrs Elaine Braithwait — ADDRESS: Rt 4 Box 44

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

203X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Myeloma — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/24, 1957 *to* 10/15, 1967, *that I last saw the deceased alive on* 10/15, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 546 (Degree or title) 1
23b. ADDRESS: Idaho Falls, Ida
23c. DATE SIGNED: 10/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Oct. 17, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 26, 1967
REGISTRAR'S SIGNATURE: Anna Bridger
25. EMBALMER: Leo A Williams
LICENSE NO.: E-319

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 3 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4389
Local Reg. No. 373
Reg. Dist. No. 611

RECEIVED NOV 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 100 000
b. CITY OR TOWN: Rural Rt# 1 Ida. Falls
LENGTH OF STAY (in this place): 0
d. FULL NAME OF HOSPITAL OR INSTITUTION: 2 mi. E. Beeches Corner 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 100
c. CITY OR TOWN: Rural Rt#1 Box 172, Ida. Falls, Ida
d. STREET ADDRESS (If rural, give location): Box 172, Rt.#1 Ida. Falls, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) JAY b. (Middle) * c. (Last) ADAMSON

4. DATE OF DEATH: (Month) Oct. (Day) 15, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 5, 1920

9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21

10b. KIND OF BUSINESS OR INDUSTRY: Automobile

11. BIRTHPLACE (State or foreign country): Pegram, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Earl L. Adamson — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Viola McClelland — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II 4

16. SOCIAL SECURITY NO.: 519-07-2508

17. INFORMANT'S OWN SIGNATURE: Mrs. Jay Adamson — ADDRESS: Rt #1 Idaho Falls, Idaho

5871

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HYPOGLYCEMIA (52 MG%); & HYPERPOTASSEMIA 8.25 MG% (CARDIAC ARREST SECONDARY)

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) FATTY LIVER

DUE TO (c) ACUTE AND CHRONIC ALCOHOLISM

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* BLOOD ALCOHOL 392 MG/CC

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NONE

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS BONNEVILLE IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hazel L McGaffey HAZEL L. MC GAFFEY, M.D. CORONER

23b. ADDRESS: 2525 SOUTH BOULEVARD

23c. DATE SIGNED: 10/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: October 18, 67

24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 21, 1967

REGISTRAR'S SIGNATURE: Irma Burfiend

25. EMBALMER: Buck Sweeney — LICENSE NO.: E-387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV. 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 2 1967 Bureau of Vital Statistics

State File No. 4300
Local Reg. No. [redacted]
Reg. Dist. No. 16

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls — c. LENGTH OF STAY (In this place): 100 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1159 Blaine Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 16 — b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1159 Blaine Ave

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ephraim	Jacob	Thompson	October 17 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	December 16, 1873	93		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Bloomington, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Pete Thompson	Denmark	Mary Jensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 07 4481 D	Ephraim Thompson	Idaho Falls, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hyper Tension — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Aug, 1967, *to* Oct 17, 1967, *that I last saw the deceased alive on* Oct 1, 1967, *and that death occurred at* 5:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David N. Smith	479 M.D.	Idaho Falls, Idaho	10/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/20/67	Fielding Memorial Park	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 28-67	Emma Rudges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 23 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4341
Local Reg. No. 319
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 2 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 000
b. CITY OR TOWN Idaho Falls,
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16 b. COUNTY Bingham 011
c. CITY OR TOWN Shelley, Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Milton	John	Kelley	Oct	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Feb 28 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) American Fork Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE John Elijah Kelley, American Fork, Utah
14. MOTHER'S MAIDEN NAME BIRTHPLACE Mary Ann Oler, American Fork, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes W.W. I
16. SOCIAL SECURITY NO. 519-42-9942
17. INFORMANT'S OWN SIGNATURE Mrs Lillian Stoddart ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate metastases
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19__ to 10-19, 1967 that I last saw the deceased alive on 10-19, 1967, and that death occurred at 4:15 P. m., from the causes and on the date stated above.

23a. SIGNATURE Glendell Petty, MD (Degree or title)
23b. ADDRESS Shelley, Idaho
23c. DATE SIGNED 10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 23 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY Hill Crest
24d. LOCATION (City, town, or county) (State) Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG. Oct 24-67
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Floyd M. Nalder
LICENSE NO. E-275
FIRM NAME: Nalder's Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 [illegible]

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 30 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4392
Local Reg. No. 323
Reg. Dist. No. 610

RECEIVED STATE OF IDAHO

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 10 Bonneville NOV 6 1967 080
b. CITY OR TOWN Idaho Falls
c. LENGTH OF STAY (If outside corporate limits, write RURAL and give township) (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION doa Sacred Heart Hospital 004

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 10 b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 725 Saturn Ave

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JOHN	LEONARD	ENELL	Oct.	19,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct. 16, 1905	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe fitter 21	Plumbing	Park City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Enell	Finland	Louise Ecklund	Vosa, Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II 4	520-05-5822	Nancy Louise Enell	725 Saturn, IF, I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cor Pulmonale — 6 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-31, 1957, *to* 10-19, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald 546 MD	Idaho Falls, Idaho	10/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/23/67	New Sweden Cemetery	Idaho Falls, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 30 - 1967	Emma Burgess	Buck Sullivan	E 387

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4393
Local Reg. No. 324
Reg. Dist. No. 610

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1465 Jefferson

3. NAME OF DECEASED (Type or Print)
a. (First): Shirlene
b. (Middle):
c. (Last): Snelson

4. DATE OF DEATH (Month) (Day) (Year): Oct 19, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): student
8. DATE OF BIRTH: 15 Nov 1954
9. AGE (In years last birthday): 12 — IF UNDER 1 YEAR: Months 11, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Snelson — BIRTHPLACE: Bellgrade Nebraska
14. MOTHER'S MAIDEN NAME: Georgia Hammon — BIRTHPLACE: Idaho Falls, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Robt Snelson — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) SEVERED CERVICAL SPINAL CORD AT BASE OF SKULL; SEVERED VERTEBRAL ARTERIES.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) 22 CALIBER BULLET WOUND TO BASE OF SKULL, RIGHT OCCIPUT, ACCIDENTAL

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: MINUTES

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT, SUICIDE, HOMICIDE (Specify): ACCIDENTAL
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): HOME
21c. (CITY, TOWN, OR TOWNSHIP) IDAHO FALLS (COUNTY) BONNEVILLE (STATE) IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hazel L. McGaffey, M.D. CORONER
23b. ADDRESS: 2525 SOUTH BOULEVARD AVE
23c. DATE SIGNED: 10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 23, Oct 1967
24c. NAME OF CEMETERY OR CREMATORY: Monarch Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct 30-1967
REGISTRAR'S SIGNATURE: Anna Burgess
25. EMBALMER: Geo A Williams
LICENSE NO.: E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

DISINTERMENT PERMIT

RECEIVED
BUREAU OF
VITAL STATISTICS
OCT 5 10 26 AM '73

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Shirlene Snelson

now lying buried in Monarch Cemetery, in the City or Town of Idaho Falls

County of Bonneville State of Idaho, who died on the 19th day of October, 1967, Aged 12 years ____ months ____ days, the cause of death being Accidental Shooting and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

Hazel L. McGaffey, M.D., Coroner attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by private private or railway conveyance

to Iona Cemetery in the City or Town of Iona County of Bonneville

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of Bonneville it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 9th day of October, A.D. 19 73.

Permit issued to:
Buck-Sullivan Funeral Home
325 East 17th Street
Idaho Falls, Idaho 83401

Janet M. Wick
by Director, Division of Vital Statistics

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of ____ State of Idaho, this ____ day of ____, 19__.

Health Officer

FORM BH 56-019

TITLE 39, CHAPTER 2, VOL. 7 OF THE IDAHO CODE

"Sec. 39-211. No body shall be disinterred within the State of Idaho except upon a permit granted by the State Board of Health. The forms of disinterment permits shall be prepared by the State Board of Health. Disinterment and removal must be done under the personal supervision of a licensed embalmer, and must be done at an hour when there is the least possible exposure. Only such persons as are actually necessary shall be present. The coffin shall not be opened either at place of disinterment or place of destination, except special permit be issued by the State Board of Health. And in case of disinterment of bodies dead by reason of contagious and infectious diseases, as shown by the certificate of death given by the attending physician, the sexton and all other persons engaged in such removal or being present shall immediately thereafter change their clothing and properly disinfect their hands, head and face, provided, that such disinterment may also be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every permit: provided, also, that in case of any contagious and infectious disease where remains are to be shipped to points in other states, permission must first be obtained from the Secretary of State Board of Health of such State. The State Board of Health may also issue a special disinterment permit for legal purposes. This permit for legal purposes shall be granted only upon application of a prosecuting attorney or the Attorney General of this State, stating therein such facts which make it evident to the State Board of Health that the ends of justice require that disinterment be permitted. Such special disinterment for legal purposes shall be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every such special disinterment permit for legal purposes."

State File No. 4394
Local Reg. No. 322
Reg. Dist. No. 616

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 6 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Bonneville 101 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

c. LENGTH OF STAY (If in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 101

b. COUNTY: Bonneville

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

d. STREET ADDRESS (If rural, give location): Route 5

3. NAME OF DECEASED (Type or Print)

a. (First): Irvin

b. (Middle): Herman

c. (Last): Pieper

4. DATE OF DEATH (Month) (Day) (Year): Oct 19, 1967

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single

8. DATE OF BIRTH: 6 May 1905

9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months 5, Days 13 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cushing, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: John Pieper — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Minnie Eggebrecht — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): War 2 4

16. SOCIAL SECURITY NO.: 519-42-7589

17. INFORMANT'S OWN SIGNATURE: W. E. Pieper — ADDRESS: R-5 Idaho Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): CORONARY ARTERIOSCLEROSIS, CALCIFIC WITH SEVERE STENOSIS — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): GENERALIZED ARTERIOSCLEROSIS

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: GOITER, Hyperplasia suggesting Hyperthyroidism

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NONE

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP): IDAHO FALLS — (COUNTY): BONNEVILLE — (STATE): IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hazel L. McGaffey HAZEL L. MC GAFFEY, M. D. CORONER 583

23b. ADDRESS: 2525 SOUTH BOULEVARD

23c. DATE SIGNED: 10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 24 Oct 1967

24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 30-67

REGISTRAR'S SIGNATURE: Anne Becker

25. EMBALMER: Leo A. Williams — LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

State File No. 4395
Local Reg. No. 325
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 10 / Bonneville
b. CITY OR TOWN Idaho Falls
c. LENGTH OF STAY IN this place 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 260
b. COUNTY Jefferson
c. CITY OR TOWN Roberts
d. STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print)
a. (First) LILLIAN
b. (Middle) LORINDA
c. (Last) LEDVINA

4. DATE OF DEATH (Month) (Day) (Year) Oct. 23, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 26, 1899
9. AGE (In years last birthday) 68
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse 13
10b. KIND OF BUSINESS OR INDUSTRY Medical
11. BIRTHPLACE (State or foreign country) Hallson, North Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Surerus
BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Lorinda Geiger
BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-44-7799
17. INFORMANT'S OWN SIGNATURE Edward Ledvina
ADDRESS Roberts, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia 493X
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cor pulmonale

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-7-, 1966 *to* 10-23-, 1967, *that I last saw the deceased alive on* 10-23-, 1967, *and that death occurred at* 10:04 A m., *from the causes and on the date stated above.*

23a. SIGNATURE John L. McMillan 348 (Degree or title) M.D.
23b. ADDRESS Idaho Falls, Idaho.
23c. DATE SIGNED 10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY Rose Hill
24d. LOCATION (City, town, or county) (State) Idaho Falls Bonneville Ida.

DATE REC'D BY LOCAL REG. Oct. 30 - 1967
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Bruce A. Eckersell Bruce A. Eckersell
LICENSE NO. E-404

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Eckersell Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 7 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

BIRTH NO. NOV 6 1967

Certificate of Death

STATE OF IDAHO

State File No. 4396
Local Reg. No. 326
Reg. Dist. No. 610

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Blackfoot
d. STREET ADDRESS (If rural, give location) Route #1 (Rose)

3. NAME OF DECEASED (Type or Print)
a. (First) Yvonne
b. (Middle)
c. (Last) Aitken

4. DATE OF DEATH (Month) (Day) (Year) Oct. 24, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: April 20, 1928
9. AGE (In years last birthday): 39 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife -St. Nurse
10b. KIND OF BUSINESS OR INDUSTRY: 13 Home & Ricks College
11. BIRTHPLACE (State or foreign country): Lewisville, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. Bruce Wilson — BIRTHPLACE: Coltman, Idaho
14. MOTHER'S MAIDEN NAME: Lucille Barney — BIRTHPLACE: Spanish Fork, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-28-3339
17. INFORMANT'S OWN SIGNATURE: Vern A. Aitken — ADDRESS: Rt. 1, Blackfoot

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) brain stem dysfunction — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) brain stem contusion — 4 days

DUE TO (c) basal skull fracture — 4 days

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: 10-21-67
19b. MAJOR FINDINGS OF OPERATION: left cerebral angiogram and spinal tap
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT X SUICIDE HOMICIDE (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): street 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 000 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10- 20- 67 m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? auto accident

22. *I hereby certify that I attended the deceased from* 10-21-67, 19__, *to* 10-24-67, 19__, *that I last saw the deceased alive on* 10-24-67, 19__, *and that death occurred at* 10 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE: George Barnard MD 027 (Degree or title) M.D. 1
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 10-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 10-27-67
24c. NAME OF CEMETERY OR CREMATORY: Grant Cemetery
24d. LOCATION (City, town, or county) (State): Grant, Bonneville, Idaho

DATE REC'D BY LOCAL REG.: Oct. 30 1967
REGISTRAR'S SIGNATURE: Anna Bridge
25. EMBALMER: Howard Packham — LICENSE NO. E-338

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Howard Packham Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4397
Local Reg. No. 529
Reg. Dist. No. 610

RECEIVED NOV 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 1 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 460 West 15th St. Ida. Falls 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 460 West 15th Street
d. STREET ADDRESS (If rural, give location) Idaho Falls, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) FERN
b. (Middle) ELLEN
c. (Last) GROSS

4. DATE OF DEATH (Month) (Day) (Year) Oct. 24, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH June 28, 1920
9. AGE (In years last birthday) 47 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Julesburg, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry Poole — BIRTHPLACE Julesburg, Colo
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 508-18-3513
17. INFORMANT'S OWN SIGNATURE Walter H Gross — ADDRESS Ida. Falls, I.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Death due to Strangulation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Suicide, hanging by neck with a rope
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* (Menopausal age) - Clinical Symptoms of depression

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 01
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 000 **(STATE)**
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Paul L. McDaffee 583 (Degree or title) MD Coroner 4
23b. ADDRESS 2525 So Boulevard
23c. DATE SIGNED 11/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 10/28/67
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) Idaho Falls, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 9-67
REGISTRAR'S SIGNATURE Anna Budger
25. EMBALMER Bill Sullivan
LICENSE NO. E 387

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck Funeral Home

MAY 9 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 12 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4398
Local Reg. No. 338
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 8 0 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 10 Bonneville — 206
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF STAY (in this place) 10
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 35 North Dakota
b. COUNTY 555 Divide
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Crosby
d. STREET ADDRESS (If rural, give location) *

3. NAME OF DECEASED (Type or Print)
a. (First) HALFRID
b. (Middle) *
c. (Last) MYHR

4. DATE OF DEATH (Month) (Day) (Year) October 24. 1967

5. SEX Fem.

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid. 2

8. DATE OF BIRTH Oct. 21, 1890

9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Sogen, Norway

12. CITIZEN OF WHAT COUNTRY? Norway

13. FATHER'S NAME Mons Brekken — BIRTHPLACE Norway

14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 502-12-9889-D

17. INFORMANT'S OWN SIGNATURE Ivar M. Myhr — ADDRESS 2240 Baltic, IF.I

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) c myocardial infarction
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 9, *19* 67, *to* Oct. 23, *19* 67, *that I last saw the deceased alive on* Oct. 23, *19* 67, *and that death occurred at* 4:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE G.W. Corbett, M.D. (Degree or title)

23b. ADDRESS 798 South Blvd, Idaho Falls, Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 10/25/67

24c. NAME OF CEMETERY OR CREMATORY Concordia Cemetery

24d. LOCATION (City, town, or county) (State) Crosby, North Dakota

DATE REC'D BY LOCAL REG. Nov. 9-1967

REGISTRAR'S SIGNATURE Anna Burgess

25. EMBALMER. Buck Funeral Home — LICENSE NO. E 387

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

DUTIES:

MAR 11 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4399
Local Reg. No. 331
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 28 1967 Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 112
b. CITY OR TOWN: Idaho Falls
c. LENGTH OF STAY (in this place): 12 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 10
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): 280 1st Street

3. NAME OF DECEASED (Type or Print): a. (First) AMOS b. (Middle) * c. (Last) WILCOX

4. DATE OF DEATH: (Month) Oct. (Day) 27, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Feb. 4, 1886

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher, ret. 04

10b. KIND OF BUSINESS OR INDUSTRY: Livestock

11. BIRTHPLACE (State or foreign country): Saratoga, Wyo.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John F. Wilcox — BIRTHPLACE: Council Bluffs, Iowa

14. MOTHER'S MAIDEN NAME: Emma Baggott — BIRTHPLACE: Birmingham, England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-42-9952

17. INFORMANT'S OWN SIGNATURE: Lydia M. Wilcox — ADDRESS: 280 1st I.F.Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute & chronic Pyelonephritis — 1 year
DUE TO (c) Acute & chronic Prostatitis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Osteomyelitis Spine — unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* April, 1967, *to* 27 Oct, 1967, *that I last saw the deceased alive on* 27 Oct, 1967, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 503 W. Stoddard M.D.

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: 4 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 31, 67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 9-1967

REGISTRAR'S SIGNATURE: Anna Rudjea

25. EMBALMER: Bert Sullivan — LICENSE NO.: E 387

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4400
Local Reg. No. 332
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 100
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): Route # 2 Box 211

3. NAME OF DECEASED (Type or Print)
a. (First): Edythe
b. (Middle):
c. (Last): Sargent

4. DATE OF DEATH (Month) (Day) (Year): October 28 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 26, 1899
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jesse Astle — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Anna Greenwood — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Vaughn Sargent — ADDRESS: Rigby, Idaho

18. CAUSE OF DEATH 1538
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of colon, with metastases. — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 10-24-57 1-24-64 10-18-67
19b. MAJOR FINDINGS OF OPERATIONS: Carcinoma of colon
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-24-57, 19__, *to* Oct 28, 1967, *that I last saw the deceased alive on* Oct 28, 1967, *and that death occurred at* P. M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Vaughn Sargent 359 — **23b. ADDRESS**: 1544 4th Idaho Falls — **23c. DATE SIGNED**: 11/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/31/67
24c. NAME OF CEMETERY OR CREMATORY: Grant Central Cemetery
24d. LOCATION (City, town, or county) (State): Jefferson County Idaho

DATE REC'D BY LOCAL REG.: Nov. 4 1967
REGISTRAR'S SIGNATURE: Anna Bredger
25. EMBALMER: Ralph M. Wood Ralph M. Wood — LICENSE NO. 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4401
Local Reg. No. 333
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 2 0 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 10 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1344 Sage Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Arthur		Allgood	October 28 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	December 25, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer	08 City of Idaho Falls	Wilford, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Allgood	USA	Emma Birch	USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 26 1285	Dian B. Allgood	Rigby, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ASHD

33 2X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan, 19 64, *to* Oct 28, 19 67, *that I last saw the deceased alive on* Oct 28, 19 67, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Byron Weeks MD	1585 So Boulevard	11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/31/67	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 9-1967	Emma Budge	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4402
Local Reg. No. 324
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 100 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 3 mi w. I.Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) doa Sacred Heart Hosp. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 101 b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 2284 Koro Dr.
d. STREET ADDRESS (If rural, give location) Idaho Falls, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) DANIEL b. (Middle) FRANK c. (Last) CAPEZUTO

4. DATE OF DEATH (Month) (Day) (Year) Oct. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Single	April 4, 1953	14				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	High School	Wilkinsburg, PA.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Capezuto	Wilmerding, Pa.	Lois Gunn	Sioux City, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-64-3711	Orland R. Capezuto	2284 Koro Ida. Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound to head — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 22 Caliber bullet — Accidental Shooting
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	00	B	000	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hazel L McCaffery MD 349	2525 So. Boulevard	11/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct. 31, 67	Penn-Lincoln Mem. Park	East McKeesport, Pa.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 9-1967	Anna Rudges	Buck Sullivan	E-387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4403
Local Reg. No. 334
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 170
b. COUNTY: Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dubois
d. STREET ADDRESS (If rural, give location): Box 113

3. NAME OF DECEASED (Type or Print)
a. (First): Benjamin
b. (Middle): Hobson
c. (Last): Thomas

4. DATE OF DEATH (Month) (Day) (Year): October 29 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: December 23, 1897
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stockman & Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Cattle & Sheep
11. BIRTHPLACE (State or foreign country): Medicine Lodge, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Benjamin D. Thomas — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Matilda Waylett — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 36 3774
17. INFORMANT'S OWN SIGNATURE: Annie L Thomas — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertention — 4 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* October 29 1967, *to* October 29, 1967, *that I last saw the deceased alive on* 29 Oct, 1967, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph M Hatch 211 MD
23b. ADDRESS: Idaho Falls Idaho
23c. DATE SIGNED: 1 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/2/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Nov. 9-1967
REGISTRAR'S SIGNATURE: Anna Budzer
25. EMBALMER: Ralph M. Wood — LICENSE NO. 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 15 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4404
Local Reg. No. 46-67
Reg. Dist. No. 100

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 27 Montana 553
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Troy
d. STREET ADDRESS (If rural, give location): P. O. Box #76

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): RUSSELL
c. (Last): LeCOUNT

4. DATE OF DEATH (Month) (Day) (Year): October 4, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: April 3, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 6 Days 1; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Bonners Ferry, Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Virgil LeCount
BIRTHPLACE: Norton, Kansas
14. MOTHER'S MAIDEN NAME: Dolly Johnson
BIRTHPLACE: Baudette, Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Virgil LeCount
ADDRESS: Troy, Montana

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Downe's Syndrome — Congenital

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/3, 1967, *to* 10/4, 1967, *that I last saw the deceased alive on* 10/3, 1967, *and that death occurred at* 30 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 103 (Degree or title) 1
23b. ADDRESS: Bonners Ferry
23c. DATE SIGNED: 10/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/7/67
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county): Bonners Ferry (State): Idaho

DATE REC'D BY LOCAL REG.: 10/10/67
REGISTRAR'S SIGNATURE: Troyla Stone
25. EMBALMER: [signature]
LICENSE NO.: E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: D-67-3420 NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4405
Local Reg. No. 47-67
Reg. Dist. No. 100

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 23 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 10 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Safeway Food Store 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 110
b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) P. O. Box #88

3. NAME OF DECEASED (Type or Print)
a. (First) ROBERT
b. (Middle) COLLIER
c. (Last) MAYO

4. DATE OF DEATH (Month) (Day) (Year) October 11, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 15, 1916
9. AGE (In years last birthday) 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Manager 26
10b. KIND OF BUSINESS OR INDUSTRY Retail Food Store
11. BIRTHPLACE (State or foreign country) Newtonville, Massachusetts
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Harry C. Mayo — BIRTHPLACE Massachusetts
14. MOTHER'S MAIDEN NAME Lillian Mae Mitchell — BIRTHPLACE Massachusetts

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 023-18-2296
17. INFORMANT'S OWN SIGNATURE Jean M. Mayo — ADDRESS Bonners Ferry Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

983X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple cerebral contusions &

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) massive skull fractures
DUE TO (c) Trauma sustained from blunt instrument

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Instant

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Homicide 3
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Safeway Food Store 19
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 110 **(STATE)** Bonners Ferry, Boundary, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10/11/67 8:00A.m.
21e. INJURY OCCURRED WHILE AT WORK [X] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR? Struck on head by blunt instrument

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE C. M. Callahan — 583 (Degree or title) Coroner 4
23b. ADDRESS Bonners Ferry, Idaho
23c. DATE SIGNED 10/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/13/67
24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery
24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 19, 1967
REGISTRAR'S SIGNATURE Twyla Stone
25. EMBALMER Charles Malone
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 20 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 18 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

AUG 15 1968

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of disposition of the deceased.

FEB 9 1971

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

AUG 25 1982

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4406
Local Reg. No. 48-67
Reg. Dist. No. 100

BIRTH NO.

OCT 23 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Boundary 110 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route #1, Paradise Valley 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 110
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) IRWIN c. (Last) SCHUON

4. DATE OF DEATH: (Month) (Day) (Year) October 11, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: January 4, 1930

9. AGE (In years last birthday): 37 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Assistant Manager 26

10b. KIND OF BUSINESS OR INDUSTRY: Retail Food Store

11. BIRTHPLACE (State or foreign country): Carlton, Michigan

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Clarence H. Schuon — BIRTHPLACE: Michigan

14. MOTHER'S MAIDEN NAME: Mary Spangler — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): Korean Conflict 1960

16. SOCIAL SECURITY NO.: 385-22-4645

17. INFORMANT'S OWN SIGNATURE: Mrs. Joyce Schuon — ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Gunshot Wound to Right Temple with underlying penetration of brain — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Brain hemmorhage due to trauma, unknown — Unknown

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Farm Paradise Valley 42
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 110 **(STATE)**: Bonners Ferry, Boundary, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10/11/67 9:10 A.M.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?: Self inflicted gunshot wound

INVESTIGATION ONLY

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: C. M. Callahan 583 — (Degree or title): Coroner 4
23b. ADDRESS: Bonners Ferry, Idaho
23c. DATE SIGNED: 10/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/14/67
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.: Oct. 19, 1967
REGISTRAR'S SIGNATURE: Evelyn Stone
25. EMBALMER:
LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 19 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) After a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-10764

BIRTH NO.

RECEIVED

OCT 26 1967

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4407
Local Reg. No. 49-67
Reg. Dist. No. 100

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 21 hours 421
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 110
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): P. O. Box #564

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	VICKI	JEAN	GROSS	October 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married 1	October 16, 1967				21	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Bonners Ferry, Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Roy Gross — BIRTHPLACE: Bonners Ferry, Idaho
14. MOTHER'S MAIDEN NAME: Marie Scott — BIRTHPLACE: Dos Palos, California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Roy N Gross — ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7230

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth, 19__, to 10/17, 19 67, *that I last saw the deceased alive on* 10/17, 19__, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD — **23b. ADDRESS**: Bonners Ferry — **23c. DATE SIGNED**: 10/18

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/18/67
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.: Oct. 20, 1967
REGISTRAR'S SIGNATURE: Virgyla Stone
25. EMBALMER: [signature]
LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4408
Local Reg. No. 50-67
Reg. Dist. No. 100

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 20 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home-103 Harrison Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 110
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): 103 Harrison Street

3. NAME OF DECEASED (Type or Print)
a. (First): LARS
b. (Middle): ALFRED
c. (Last): STONKLIFT

4. DATE OF DEATH (Month) (Day) (Year): October 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: October 1, 1876
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motel Owner 22
10b. KIND OF BUSINESS OR INDUSTRY: Commercial
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Lars Larson Stonklift — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-05-4797
17. INFORMANT'S OWN SIGNATURE: Ruby G. Maxfield — ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): C.V.A. — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis — yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Hypertension

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1960, *to* 10/18, 1967, *that I last saw the deceased alive on* 10/17, 1967, *and that death occurred at* 3A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 153 (Degree or title) MD
23b. ADDRESS: Bonners Ferry Ida
23c. DATE SIGNED: 10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/21/67
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county): Bonners Ferry (State): Idaho

DATE REC'D BY LOCAL REG.: 10/24/67
REGISTRAR'S SIGNATURE: Twyla Stone
25. EMBALMER: [signature]
LICENSE NO.: E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4409
Local Reg. No. 7
Reg. Dist. No. 6 70

RECEIVED NOV 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Butte 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco
LENGTH OF STAY (in this place) 002
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Lost Rivers Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Custer 190
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mackay
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	BOBBY	DE WAYNE	CASEBOLT	September 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married 1	Sept. 26, 1966	1				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Infant 02	None	Laurinburg, N. Carolina	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David R. Casebolt	Steelvilles, Va.	Shirley Mintz	Raeford, N. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		None	X David R. Casebolt	Mackay, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

291X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Iron Deficiency Anemia — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Bronchitis — 24 hrs
DUE TO (c) Acute Pneumonia — 24 hrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 9-28, 1967, *to* 9-29, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
031 D. Bartlett MD	Arco, Idaho	10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial 3	10-2-67	Wichita Park	Wichita, Kansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Betty J. Marvel	C. H. Marvel	E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 15 1987

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4410
Local Reg. No.
Reg. Dist. No.

RECEIVED OCT 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Camas 130 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. Gooding Hospital 032

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 320 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) STANLEY b. (Middle) LUNDEGREN c. (Last) LARSON

4. DATE OF DEATH: (Month) Oct. (Day) 8, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 18, 1905
9. AGE (In years last birthday): 62 IF UNDER 1 YEAR Months: 5 Days: 20 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conservation Officer
10b. KIND OF BUSINESS OR INDUSTRY: Fish & Game Dept.
11. BIRTHPLACE (State or foreign country): Preston, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles August Larson
BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Abby Lundegren
BIRTHPLACE: Weston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-07-5931
17. INFORMANT'S OWN SIGNATURE: Mrs. Stanley L. Larson
ADDRESS: Shoshone

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Internal Injuries
INTERVAL BETWEEN ONSET AND DEATH: 3 hr 45 Min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Crushed By Horse
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Forest 26 Mi No Fairfield
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 130 Camas (STATE) Ida

21d. TIME OF INJURY (Month) Oct (Day) 8. (Year) 1967 (Hour) 7:30 P.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Horse fell on him

22. *I hereby certify that I attended the deceased from* Oct 8, 19 67, to ____, 19__, *that I last saw the deceased alive on* Oct 8, 19 67, *and that death occurred at* 11:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Marion J Kerns M.D. 583 (Degree or title) Coroner
23b. ADDRESS: Fairfield Idaho
23c. DATE SIGNED: 13 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-12-1967
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 13 Oct 1967
REGISTRAR'S SIGNATURE: Estelle Vaught
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463
FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 10 1967 Bureau of Vital Statistics

State File No. 4411
Local Reg. No. 107
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 000
b. CITY OR TOWN (If outside corporate limits, write township): NAMPA
LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 140
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL NAMPA
d. STREET ADDRESS (If rural, give location): ROUTE 3

3. NAME OF DECEASED (Type or Print)
a. (First): ELIZABETH
b. (Middle): GARCIA
c. (Last):

4. DATE OF DEATH: (Month) OCT. (Day) 1, (Year) 1967

5. SEX: FEMALE
6. COLOR OR RACE: MEXICAN
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): NEVER MARRIED /
8. DATE OF BIRTH: OCT. 13, 1956
9. AGE (In years last birthday): 10 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): STUDENT 23
10b. KIND OF BUSINESS OR INDUSTRY: EASTSIDE SCHOOL
11. BIRTHPLACE (State or foreign country): PHARR, TEXAS
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JESS SORIA
BIRTHPLACE: TEXAS
14. MOTHER'S MAIDEN NAME: ALICE GARCIA
BIRTHPLACE: MEXICO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S OWN SIGNATURE: x Robert J. Garcia
ADDRESS: NAMPA,

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8164

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Accidental Drowning
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto accident
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Laceration + Contusion scalp.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident /
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): on highway 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 140 (STATE): So. Powerline Road. Canyon. Idaho
21d. TIME OF INJURY (Month) Oct (Day) 1 (Year) 1967 (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?: Auto Collision - Thrown out of car into canal.

22. *I hereby certify that I attended the deceased from* Inspection & Autopsy only *, 19__, to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at __ m., from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wesche M.D. 583 (Degree or title) Coroner. 4
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL /
24b. DATE: 10-6-67
24c. NAME OF CEMETERY OR CREMATORY: MT. CALVARY CEMETERY
24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Oct. 9, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4412
Local Reg. No. 108
Reg. Dist. No. 360

RECEIVED OCT 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 14 — 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (In this place): 2 WKS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 14
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 116 1st STREET NORTH EXT.

3. NAME OF DECEASED (Type or Print): a. (First) CHARLIE b. (Middle) A. c. (Last) DAVIS

4. DATE OF DEATH: (Month) (Day) (Year): OCT. 1, 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3

8. DATE OF BIRTH: SEPT. 29, 1887

9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER 04

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): TINGLEY, IOWA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN DAVIS — BIRTHPLACE: NO RECORD

14. MOTHER'S MAIDEN NAME: LAURA EDWARDS — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 518-16-7421

17. INFORMANT'S OWN SIGNATURE: Mame L Davis — ADDRESS: NAMPA, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes Mellitus — Fracture Rt. femur

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-13, 1966, *to* Oct 1, 1967, *that I last saw the deceased alive on* Oct 1, 1967, *and that death occurred at* 1:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C Wesche 560 (Degree or title) MD

23b. ADDRESS: NAMPA, IDAHO

23c. DATE SIGNED: 10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: 10-4-67

24c. NAME OF CEMETERY OR CREMATORY: KOHLER LAWN CEMETERY

24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Oct. 9, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: M. B. Shepherd — LICENSE NO.: 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4413
Local Reg. No. 113
Reg. Dist. No. 360

RECEIVED
OCT 12 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 1 WK
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 142
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 211 19th AVE. SOUTH

3. NAME OF DECEASED (Type or Print)
a. (First): EDNA
b. (Middle): KOCH
c. (Last): UBERUAGA

4. DATE OF DEATH (Month) (Day) (Year): OCT. 1, 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: MAY 4, 1896
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE 01
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): CHICAGO, ILLINOIS
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: GERHARD KOCH — BIRTHPLACE: ILLINOIS
14. MOTHER'S MAIDEN NAME: ANNA LARSON — BIRTHPLACE: NORWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-42-4936
17. INFORMANT'S OWN SIGNATURE: Lorenzo Uberuaga — ADDRESS: NAMPA, IDAH

18. CAUSE OF DEATH 1533
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of
DUE TO (c) sigmoid colon

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-10-, 19 66, *to* 10-1-, 19 67, *that I last saw the deceased alive on* 10-1-, 19 67 *and that death occurred at* 1:40P *m., from the causes and on the date stated above.*

23a. SIGNATURE: S C [signature] 524 (Degree or title) 1
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 10-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL 7
24b. DATE: 10-4-67
24c. NAME OF CEMETERY OR CREMATORY: KOHLERLAWN CEMETERY
24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Oct. 11, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 9 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 9 1967 Bureau of Vital Statistics

State File No. 4414
Local Reg. No. 106
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 140 (OCT 9 1967) 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 116
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middleton
d. STREET ADDRESS (If rural, give location): Box 171

3. NAME OF DECEASED (Type or Print): a. (First) Thomas b. (Middle) Homer c. (Last) Anderson

4. DATE OF DEATH (Month) (Day) (Year): Oct. 1, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Nov. 8, 1887

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Chillocothe, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William A. Anderson — BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Mary Alice Schaffer — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): War I 3

16. SOCIAL SECURITY NO.: 518-40-0597

17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4201 Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary thrombosis

DUE TO (c) Coronary sclerosis.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept 25, 1967 *to* Oct 1, 1967, *that I last saw the deceased alive on* Oct 6, 1967, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D. — **23b. ADDRESS**: Caldwell Idaho — **23c. DATE SIGNED**: 10-3

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Oct. 4, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Cloverdale Cemetery — **24d. LOCATION** (City, town, or county) (State): Boise, Idaho 67

DATE REC'D BY LOCAL REG.: Oct. 6, 1967 — **REGISTRAR'S SIGNATURE**: Mrs. Martina Walmsley — **25. EMBALMER**: Merville R. Davis — **LICENSE NO.**: E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4415
Local Reg. No. 112
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 12 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: CANYON 404
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): FEW HRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON 140
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA (RURAL)
d. STREET ADDRESS (If rural, give location): ROUTE 1

3. NAME OF DECEASED (Type or Print): a. (First) TWILA b. (Middle) B. c. (Last) PAUL

4. DATE OF DEATH (Month) (Day) (Year): OCT. 1, 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3

8. DATE OF BIRTH: MARCH 4, 1926

9. AGE (In years last birthday): 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NURSING 13

10b. KIND OF BUSINESS OR INDUSTRY: IDA. STATE HOSPITAL

11. BIRTHPLACE (State or foreign country): WRAY, COLORADO

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: VERNON MORRIS — BIRTHPLACE: NO RECORD

14. MOTHER'S MAIDEN NAME: LILLY GEORGE — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 506-24-6273

17. INFORMANT'S OWN SIGNATURE: x Clara Paul — ADDRESS: MELBA, IDA

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 465X Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 1-2 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1-, 1967, *to* 10-1-, 1967, *that I last saw the deceased alive on* 10-1-, 1967, *and that death occurred at* 11:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Walter Weldon (Degree or title) M.D. 217

23b. ADDRESS: NAMPA, IDAHO

23c. DATE SIGNED: 10-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: 10-6-67

24c. NAME OF CEMETERY OR CREMATORY: KOHLERLAWN CEMETERY

24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Oct. 11, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: M. B. Shepherd — LICENSE NO.: 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 26 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4416
Local Reg. No. 109
Reg. Dist. No. 360

Certificate of Death

RECEIVED
OCT 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 140 — 123
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL NAMPA
c. LENGTH OF STAY (in this place): 23 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 159 ORCHARD 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 140 CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL NAMPA
d. STREET ADDRESS (If rural, give location): 159 ORCHARD

3. NAME OF DECEASED (Type or Print)
a. (First): EVALYN
b. (Middle): L.
c. (Last): LAKEY

4. DATE OF DEATH (Month) (Day) (Year): OCT. 2, 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: DEC. 20, 1887
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE 01
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): KNOXVILLE, TENNESSEE
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: JOHN BISHOP — BIRTHPLACE: NO RECORD
14. MOTHER'S MAIDEN NAME: ANNA NOR CECORD — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-60-3930
17. INFORMANT'S OWN SIGNATURE: Ezra Lakey — ADDRESS: NAMPA, IDA.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection only *, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C Wesche M.D. 583 Coroner 4
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL 1
24b. DATE: 10-6-67
24c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY
24d. LOCATION (City, town, or county) (State): SODA SPRINGS, IDAHO

DATE REC'D BY LOCAL REG.: Oct. 9, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd — LICENSE NO. 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 9 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4417
Local Reg. No. 111
Reg. Dist. No. 360

Certificate of Death

RECEIVED
OCT 11 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Rt. 5
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, Rt. # 5 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 5

3. NAME OF DECEASED (Type or Print)
a. (First): Ben
b. (Middle): Raymond
c. (Last): Webster

4. DATE OF DEATH (Month) (Day) (Year): October 2, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 23, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months 2, Days 4 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Syracuse, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Webster — BIRTHPLACE
14. MOTHER'S MAIDEN NAME — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-42-1773
17. INFORMANT'S OWN SIGNATURE: Mrs Ben R. Webster — ADDRESS

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary — INTERVAL BETWEEN ONSET AND DEATH: 5 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASHD — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1963, *to* Aug 29, 1967, *that I last saw the deceased alive on* Aug 29, 1967, *and that death occurred at* 9:30 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wal E Raymond 437 (Degree or title) Mr 1
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: Oct 5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Oct. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Garden
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 10, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: R. W. Dakan
LICENSE NO.: E-508

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to:

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4418
Local Reg. No. 127
Reg. Dist. No. 360

RECEIVED OCT 19 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 301
b. CITY OR TOWN: NAMPA
LENGTH OF STAY (in this place): 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION: MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 143
b. COUNTY: CANYON
c. CITY OR TOWN: NAMPA
d. STREET ADDRESS (If rural, give location): 915 FLORENCE

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) c. (Last) SMITHWICK

4. DATE OF DEATH (Month) (Day) (Year): OCT. 3, 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): NEVER MARRIED

8. DATE OF BIRTH: MARCH 1, 1901

9. AGE (In years last birthday): 66 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER 04

10b. KIND OF BUSINESS OR INDUSTRY: FARMING

11. BIRTHPLACE (State or foreign country): SMITHSHIRE, ILLINOIS

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM SMITHWICK — BIRTHPLACE: NEBRASKA

14. MOTHER'S MAIDEN NAME: MARY BARRY — BIRTHPLACE: IRELAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 527-32-9883

17. INFORMANT'S OWN SIGNATURE: Gertrude Smithwick ADDRESS: BOISE, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 24+hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Pneumonia - Rt / Obstructive - Pul. Fibrosis — 1-2 wks / 10 yrs

DUE TO (c): Coronary Sclerosis — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Progressive Emphysema - Bullous - advanced — 20 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: non op - Incarcerated (ing) rt. ing hernia

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1959, 19__, *to* 3 Oct, 1967, *that I last saw the deceased alive on* 3 Oct, 1967, *and that death occurred at* 10:20 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: O.R. Riordan 443 (Degree or title) MD

23b. ADDRESS: NAMPA, IDAHO

23c. DATE SIGNED: 10 Oct 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: 10-6-67

24c. NAME OF CEMETERY OR CREMATORY: KOHLER LAWN CEMETERY

24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Oct. 18, 1967

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: M.D. Shepherd

LICENSE NO.: 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4419
Local Reg. No. 117
Reg. Dist. No. 360

BIRTH NO.

RECEIVED OCT 13 1967 Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Canyon 14 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 4th & Everett St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 13

b. COUNTY: Canyon 27

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell

d. STREET ADDRESS (If rural, give location): 1305 Cleveland Blvd.

3. NAME OF DECEASED (Type or Print): a. (First) Becky b. (Middle) Lynne c. (Last) Young

4. DATE OF DEATH (Month) (Day) (Year): Oct. 3, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant 1

8. DATE OF BIRTH: Sept. 22, 1966

9. AGE (In years last birthday): 1 — IF UNDER 1 YEAR: Months | Days: 11 — IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles D. Young — BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Barbara K. Winslow — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE X Charles Dale Young — ADDRESS:

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

8164

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken neck — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

(b) Multiple Skull fractures

DUE TO (c) Auto accident

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street 04

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 14 **(STATE)**: Caldwell Canyon Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-3-67 6 P. m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Collision at an intersection

22. *I hereby certify that I attended the deceased from* 2 Inspection only, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Weiche M.D. 583 (Degree or title) Coroner 4

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 10-10-67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 12, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Merrille D. Davis — LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4420
Local Reg. No. 110
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
OCT 10 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY in this place
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 22nd. Ave. South, Nampa

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa -Rural
d. STREET ADDRESS (If rural, give location) R# # 3

3. NAME OF DECEASED (Type or Print)
a. (First) ROBERT
b. (Middle) JAMES
c. (Last) METZGER

4. DATE OF DEATH (Month) (Day) (Year) October 3, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 14, 1922
9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Masonry
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred John Metzger — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Erma Stewart — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1942- 1945
16. SOCIAL SECURITY NO. 519-16-6056
17. INFORMANT'S OWN SIGNATURE: x Norma Metzger — ADDRESS: Nampa, Idaho R# 3

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Neck Laceration & severing Carotid artery
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) and Jugular vein
DUE TO (c) Auto accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street
21c. (CITY, TOWN, OR TOWNSHIP) Nampa (COUNTY) Canyon (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 3 - 1967 1:30A m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Head pushed thru windshield & neck cut on glass

22. *I hereby certify that I attended the deceased from* Inspection only, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wesch M.D (583) (Degree or title) Corona 4
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 10-5-67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Canyon County, Idaho

DATE REC'D BY LOCAL REG.: Oct. 9, 1967
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: Richard W. Meaubriat
LICENSE NO.: E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 11 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 13 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 8 1967

FEB 9 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4421
Local Reg. No. 119
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
OCT 16 1967
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 000
b. CITY OR TOWN: Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 16
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 5

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) L. c. (Last) Thomas

4. DATE OF DEATH: (Month) (Day) (Year) October 4, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: Aug. 16, 1905
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Witts Springs, Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin R. McGowen — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Janie Fane — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 519-24-8034
17. INFORMANT'S OWN SIGNATURE: X Mary Thomas — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer left ovary with — INTERVAL BETWEEN ONSET AND DEATH: Cancer

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) metastases to — ovary 2 years
DUE TO (c) all structures immediate surrounding

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1750

19a. DATE OF OPERATION: 3-19-63
19b. MAJOR FINDINGS OF OPERATION: Cancer left ovary
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-15, 1965, *to* 10-4, 1967, *that I last saw the deceased alive on* 10-4, 1967, *and that death occurred at* 7 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D.
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 10-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Middleton Cemetery
24d. LOCATION (City, town, or county) (State): Middleton, Idaho

DATE REC'D BY LOCAL REG.: Oct. 13, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville A Davis
LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4422
Local Reg. No. 132
Reg. Dist. No. 360

BIRTH NO.

RECEIVED STATE OF IDAHO
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141 OCT 25 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 611 Galveston

3. NAME OF DECEASED (Type or Print): a. (First) Riley; b. (Middle) C. W; c. (Last) Wyatt

4. DATE OF DEATH (Month) (Day) (Year): Oct. 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	April 19, 1885	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
*No Retired 06	Labored	Crossville, Tenn	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Sampson Wyatt	Tenn	Kathryn Selby	Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No ------	519-20-0423	Mrs Lauvette A. Wyatt	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2881 Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 5+ years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-5-60, 19__, *to* 10-4-67, 19__, *that I last saw the deceased alive on* 10-4-67, 19__, *and that death occurred at* 9:25 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
X W M Archer 250	MD	222 East Elm--Caldwell, Idaho	10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 9, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 23, 1967	Mrs. Martina Walmsley	Merville D. Davis	E-399

FIRM NAME: Peckham-Dakan Chapel Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4423
Local Reg. No. 114
Reg. Dist. No. 360

Certificate of Death

RECEIVED OCT 13 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorail Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 1324 Dewey Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) David
b. (Middle) W.
c. (Last) Howard

4. DATE OF DEATH (Month) (Day) (Year) October 5, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 9, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): salesmen 24
10b. KIND OF BUSINESS OR INDUSTRY: equipment
11. BIRTHPLACE (State or foreign country): Ladue, Missouri
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Wilkes Howard — BIRTHPLACE: No record
14. MOTHER'S MAIDEN NAME: Lula Tharp — BIRTHPLACE: No reocrd
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 500-26-0445A
17. INFORMANT'S OWN SIGNATURE: X Karrel Howard — ADDRESS: Nampa

18. CAUSE OF DEATH 5271
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Myphysema — INTERVAL BETWEEN ONSET AND DEATH: 15 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1955, *to* Oct 5, 1967, *that I last saw the deceased alive on* Oct 5, 1967, *and that death occurred at* 1:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 570 (Degree or title) MD
23b. ADDRESS: Caldwell Ida
23c. DATE SIGNED: 10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: Oct. 12, 1967
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. EMBALMER: [signature]
LICENSE NO. E-496

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 20 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4424
Local Reg. No. 128
Reg. Dist. No. 360

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 14/ Canyon
b. CITY OR TOWN Caldwell, Idaho
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 14/ Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) 1202 No. Michigan

3. NAME OF DECEASED (Type or Print)
a. (First) JAMES
b. (Middle) 05/
c. (Last) ROBY REDMAN

4. DATE OF DEATH (Month) 10 (Day) 6 (Year) 67

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH May 1, 1899

9. AGE (In years last birthday) 68
IF UNDER 1 YEAR: Months 5 Days 5
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic -2/

10b. KIND OF BUSINESS OR INDUSTRY Semi-Retired

11. BIRTHPLACE (State or foreign country) Otway, Ohio

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Wm. Redman
BIRTHPLACE Manchester, Ohio

14. MOTHER'S MAIDEN NAME Ruth Ina Kerr
BIRTHPLACE Near Manchester, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 519-09-6814

17. INFORMANT'S OWN SIGNATURE x Mrs. Ruby Redman
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor Pulmonale

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Hypertension
DUE TO (c) Pulmonary Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH: Progressive

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 Oct, 1967, *to* 6 Oct, 1967, *that I last saw the deceased alive on* 6 Oct, 1967, *and that death occurred at* 5:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Charles E. Krause (Degree or title) M.D.
23b. ADDRESS Caldwell, Idaho
23c. DATE SIGNED 16 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/10/67
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Oct. 19, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Leonard C. Flahiff
LICENSE NO. E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 6 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4425
Local Reg. No. 123
Reg. Dist. No. 360

Certificate of Death

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middleton, Idaho
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): THOMAS
b. (Middle): WILSON 051
c. (Last): HUBBARD

4. DATE OF DEATH (Month) 10 (Day) 6 (Year) 67

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Jan. 20, 1878
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months 8, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Metcalfe, Kentucky
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John C. Hubbard — BIRTHPLACE: Barren Co. Ky.
14. MOTHER'S MAIDEN NAME: Lucy L. Hayes — BIRTHPLACE: Barren CO. Ky.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-58-9718
17. INFORMANT'S OWN SIGNATURE: Mrs. Dorothy L. Davis — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral arterial occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4 Days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1, 1967 *to* 10-6, 1967, *that I last saw the deceased alive on* 10-6, 1967, *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 166 (Degree or title)
23b. ADDRESS Caldwell Idaho
23c. DATE SIGNED 10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/9/67
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Oct. 17, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4426
Local Reg. No. 122
Reg. Dist. No. 360

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 1 WK
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 142
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 315 20th AVE. SOUTH

3. NAME OF DECEASED (Type or Print)
a. (First): PABLO
b. (Middle): F.
c. (Last): ORTEGA

4. DATE OF DEATH (Month) (Day) (Year): OCT. 7, 1967

5. SEX: MALE
6. COLOR OR RACE: MEXICAN
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: FEB. 15, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER 04
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (State or foreign country): DEL NORTE, COLORADO
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: POLONERS ORTEGA — BIRTHPLACE: NEW MEXICO
14. MOTHER'S MAIDEN NAME: NECOLICES LIELES — BIRTHPLACE: NEW MEXICO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-36-6967A
17. INFORMANT'S OWN SIGNATURE: Mrs Pablo F. Ortega — ADDRESS: NAMPA, IDA.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Artery Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b) Generalized Arteriosclerosis
~~DUE TO~~ (c) Hiatus Hernia c̄ Peptic Esophagitis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/29, 1967, *to* 10/7, 1967, *that I last saw the deceased alive on* 10/7, 1967, *and that death occurred at* 9:35A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J R Mangum MD 322
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 10-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 10-12-67
24c. NAME OF CEMETERY OR CREMATORY: MT. CALVARY CEMETERY
24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Oct. 17, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 18 1978

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4427
Local Reg. No. 135
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

1. PLACE OF DEATH
a. COUNTY 142 Canyon OCT 25 1967 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 624 17th AVE. South

3. NAME OF DECEASED (Type or Print)
a. (First) FRANK b. (Middle) GEORGE c. (Last) MADISON

4. DATE OF DEATH (Month) (Day) (Year) Oct. 8, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan. 6, 1893
9. AGE (In years last birthday) 74 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 10
10b. KIND OF BUSINESS OR INDUSTRY Railroad
11. BIRTHPLACE (State or foreign country) Sandburn, Minnesota
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Pete Madison BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Mary E. Duncan BIRTHPLACE Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Mrs. Myrtle H. Madison ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) UREMIA — INTERVAL BETWEEN ONSET AND DEATH 3 mo —

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertensive ASHD c Renal Insuff — 3 years
DUE TO (c) Diabetes Mellitus 5 yrs

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death* Hypertrophic Arthritis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-16 —, 1960, *to* Oct —, 1967, *that I last saw the deceased alive on* Oct 6, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 115 (Degree or title) 23b. ADDRESS Nampa Ida 23c. DATE SIGNED 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY Cloverdale Memorial Park
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 24, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER G. W. Waters [signature]
LICENSE NO. E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 10 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 16 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 14 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4428
Local Reg. No. 118
Reg. Dist. No. 360

RECEIVED
OCT 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 810 Chicago St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jessie	O.	Sewell	Oct. 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Aug. 30, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Warren C. Duncan	Iowa	Beatrice Swainey	Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Beryl E Bonnell	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma uterus — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) congestive heart failure — 3 wks.
DUE TO (c) diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-10-67	bowel obstruction due to carcinoma of uterus	YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-9-67, 19___, *to* 10-8-67, 19___, *that I last saw the deceased alive on* 10-8-67, 19___, *and that death occurred at* 8:40a. *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A M Lahrang 425	M.D.	227 E. Logan, Caldwell, Idaho	10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 11, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 12, 1967	Mrs. Martina Walmsley	Merville D Davis	E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended October 31, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4429
Local Reg. No. 121
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 547 Fairview St.

3. NAME OF DECEASED (Type or Print): a. (First) Finley b. (Middle) W. c. (Last) Inglis

4. DATE OF DEATH (Month) (Day) (Year): October 9, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 6, 1880
9. AGE (In years last birthday): 87 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pawnee City, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alexander Inglis — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Mary McDonald — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-28-7114A
17. INFORMANT'S OWN SIGNATURE: G. A. Inglis — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebral Hemorrhage 4438 — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertensive C-V Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-5, 1956, *to* 10-9, 1967, *that I last saw the deceased alive on* 10-9, 1967, *and that death occurred at* 1:35A *m., from the causes and on the date stated above.*

23a. SIGNATURE: J. Saltzer, M.D. 454 (Degree or title)
23b. ADDRESS: Nampa
23c. DATE SIGNED: 10-11

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Canyon County, Idaho

DATE REC'D BY LOCAL REG.: Oct 16, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Don W. Sirifiari
LICENSE NO.: E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

10-24-67

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
OCT 30 1967
Bureau of Vital Statistics

State of Idaho
County of Canyon } ss.

Certificate No.

Date Filed Oct. 17, 1967

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Finley W. Inglis (Name on Original Certificate) who died (Was Born or Died) on Oct. 9, 1967 (Date of Event)
in Nampa, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Bible Record (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 8	June 1, 1885	June 6, 1880
Item 9	82	87

Subscribed and sworn to before me this 25th day of October, 19 67

X [signature]
Notary Public, residing at Nampa, Idaho
My commission expires June 15, 1969
(Seal)

X Signed [signature]
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

547 Fairview--Nampa, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Canyon } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 25th day of October, 19 67

X [signature]
Notary Public, residing at Nampa, Idaho
My commission expires June 15, 1969
(Seal)

X Signed Hilda Maxwell
(Signature of Any Credible Person)

285 Davis St--Nampa, Idaho.
(Street Address, City, State)

FORM DH 60-155

10-24-67

RECEIVED

OCT 30 1967

Oct. 17, 1967

Oct. 9, 1967

June 1, 1955
32

June 5, 1950
87

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. [ICA 38-206 and 215.] Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 121
Reg. Dist. No. 360

BIRTH NO.

OCT 17 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 547 Fairview St.

3. NAME OF DECEASED (Type or Print): a. (First) Finley; b. (Middle) W.; c. (Last) Inglis

4. DATE OF DEATH: (Month) (Day) (Year): Oct. 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: June 5, 1885

9. AGE (In years last birthday): 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pawnee City, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alexander Inglis
BIRTHPLACE: Scotland

14. MOTHER'S MAIDEN NAME: Mary McDonald
BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 28 7114A

17. INFORMANT'S OWN SIGNATURE: G. A. Inglis
ADDRESS: Boise Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (c): C-V disease — INTERVAL BETWEEN ONSET AND DEATH:

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-5- *19* 56 *to* 10-9- *, 1967, that I last saw the deceased alive on* 10-9- *, 19* 67 *and that death occurred at* 1:35A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature]

23b. ADDRESS: Nampa

23c. DATE SIGNED: 10/11

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Canyon County, Idaho

DATE REC'D BY LOCAL REG.: Oct. 16, 1967

REGISTRAR'S SIGNATURE: Mrs Martina Walmsley

25. EMBALMER: [signature]
LICENSE NO.: E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: MAR 3 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4430
Local Reg. No. 120
Reg. Dist. No. 360

RECEIVED OCT 17 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blvd. Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 149 Deleware

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) M.
c. (Last) Wohlander

4. DATE OF DEATH (Month) (Day) (Year) October 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 22, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY: Carpentry
11. BIRTHPLACE (State or foreign country): Stockholm, Sweden
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William M. Wohlander — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Anna Schillberg — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 540 10 8938
17. INFORMANT'S OWN SIGNATURE: Family records, By: Jerry S. Kranch — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of lung — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1966, *to* Oct 10, 1967, *that I last saw the deceased alive on* 8 Oct, 1967, *and that death occurred at* 7:00P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: B. Marcusen MD 326 (Degree or title)
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 10/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rest Lawn Memorial Cemetery
24d. LOCATION (City, town, or county): Eugene (State) Oregon

DATE REC'D BY LOCAL REG.: Oct. 16, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO. E-487

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 15 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 28 2000

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 18 1967 Bureau of Vital Statistics

State File No. 4431
Local Reg. No. 125
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 141 Canyon 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (in this place): 2½ Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1419 Rimview Dr. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1419 Rimview Dr.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Peter	John	Herbst	Oct.	11	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 20, 1883	83	10	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Postmaster 38	Postal	Dupack Germany	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Herbst	Dupack Germany	Elizebeth Sarteau	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	516-40-8863A	Mary Herbst	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Coronary occlusion	Instant
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	arterio sclerotic cardio-vascular disease	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Carcinoma rectum	3 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1967 *to* 11 Oct, 1967, *that I last saw the deceased alive on* 2 Sept, 1967, *and that death occurred at* 5 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 423	M.D.	Caldwell	12 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	10/12/67	St. Anthony	Plevna, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 17, 1967	Mrs. Martina (Walmsley)	Lucy M. Flaherty	E393

FIRM NAME: Flaniff Chapel Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 23 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4432
Local Reg. No. 124
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon — OCT 18 1967 — 201
b. CITY OR TOWN: Caldwell — Bureau of Vital Statistics — c. LENGTH OF STAY: 30dy
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 457

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 38 Oregon — b. COUNTY 555 Malheur
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Nyssa
d. STREET ADDRESS (If rural, give location): RFD 1 Box 238

3. NAME OF DECEASED (Type or Print): a. (First) Lawrence — b. (Middle) L — c. (Last) Kreager

4. DATE OF DEATH: (Month) (Day) (Year) 10-11-1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 3-16-1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Henry A Kreager — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Mary Doris Wolters — BIRTHPLACE: Kansas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 540-40-4049
17. INFORMANT'S OWN SIGNATURE: Bonena S Kreager — ADDRESS: RFD 1 Box 238 Nyssa Oregon

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ulcerative colitis with — INTERVAL BETWEEN ONSET AND DEATH: 30 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) multiple ulcer perforations
DUE TO (c) peritonitis - diffuse

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* mesenteric thrombosis

19a. DATE OF OPERATION: 10-5-67
19b. MAJOR FINDINGS OF OPERATION (Specify): perforations of ulcers colon
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-11, 1967, *to* 10-11, 1967, *that I last saw the deceased alive on* 10-11, 1967, *and that death occurred at* 9P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] M.D. — 23b. ADDRESS: Caldwell Idaho — 23c. DATE SIGNED: 6-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 10-16-1967
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Memorial
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: Oct. 17, 1967
REGISTRAR'S SIGNATURE: Mrs Martina Walmsley
25. FUNERAL DIRECTOR — ADDRESS: [signature] Nyssa Oregon

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DPH-48021

OCT 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

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Certificate of Death

STATE OF IDAHO

State File No. 4433
Local Reg. No. 130
Reg. Dist. No. 360

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 140 Canyon 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa, Rural
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home-- R# 3- Nampa 001

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa-- Rural
d. STREET ADDRESS (If rural, give location): R# 3

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) D. c. (Last) AGENBROAD

4. DATE OF DEATH: (Month) October (Day) 15, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 15, 1886
9. AGE (In years last birthday): 81 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: orchardist
11. BIRTHPLACE (State or foreign country): Huron, So. Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Murrel Agenbroad — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Maud Story — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 518-40-4620
17. INFORMANT'S OWN SIGNATURE: Laura M. Agenbroad — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerosis

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection only, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C Wenke M.D. 583 (Degree or title) Coroner. 4
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: Oct. 23, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4434
Local Reg. No. 131
Reg. Dist. No. 360

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 060

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa Rural
d. STREET ADDRESS (If rural, give location): R# 3

3. NAME OF DECEASED (Type or Print)
a. (First): Margaret
b. (Middle): Anna
c. (Last): Cox

4. DATE OF DEATH (Month) (Day) (Year): October 15, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: April 27, 1893

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Park City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ~~Almon~~ Cox Hurley
BIRTHPLACE: Maine

14. MOTHER'S MAIDEN NAME: Catherine McDonald
BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 26 9850

17. INFORMANT'S OWN SIGNATURE: Carl A. Cox
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4434

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hypertensive Heart Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Apparent Cardiac Arrest
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Heatus Hernia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/21, 1962, *to* Oct 15, 1967, *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at* 11:50P m., *from the causes and on the date stated above.*

23a. SIGNATURE: J.K. Mangum 322 (Degree or title) MD
23b. ADDRESS: Nampa, Idaho
23c. DATE SIGNED: 10/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 19, 1967
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State): Nampa Idaho

DATE REC'D BY LOCAL REG.: Oct. 23, 1967
REGISTRAR'S SIGNATURE: Mrs. Martine Walmsley

25. EMBALMER: Richard W. Mesenbrink
LICENSE NO.: E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4435
Local Reg. No. 134
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 CANYON 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
c. LENGTH OF STAY (in this place) 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 142 CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 407 4th AVE. SOUTH

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPH
b. (Middle) W.
c. (Last) WENDLICK

4. DATE OF DEATH (Month) OCT. (Day) 15, (Year) 1967

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2

8. DATE OF BIRTH AUG. 11, 1877

9. AGE (In years last birthday) 90
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER

10b. KIND OF BUSINESS OR INDUSTRY U.P. RAIL ROAD

11. BIRTHPLACE (State or foreign country) PARDEEVILLE, WISCONSIN

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME HENRY WENDLICK
BIRTHPLACE NO RECORD

14. MOTHER'S MAIDEN NAME NO RECORD
BIRTHPLACE NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-07-6389

17. INFORMANT'S OWN SIGNATURE Opal C. Wendlick
ADDRESS NOGALES ARIZONA

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3318

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebro-Vascular Accident
INTERVAL BETWEEN ONSET AND DEATH 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebro Arteriosclerosis
~~DUE TO (c)~~

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Pneumonia

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1958, *to* 10/15, 1967, *that I last saw the deceased alive on* 10/15/67, 19___, *and that death occurred at* 1:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE J. K. Mangum 322 (Degree or title) MD

23b. ADDRESS NAMPA, IDAHO

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 10-18-67

24c. NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY

24d. LOCATION (City, town, or county) (State) CANYON COUNTY, IDAHO

DATE REC'D BY LOCAL REG. Oct. 24, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER M. B. Shepherd
LICENSE NO. 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4436
Local Reg. No. 129
Reg. Dist. No. 360

Certificate of Death

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa - Rural
d. STREET ADDRESS (If rural, give location) R # 1

3. NAME OF DECEASED (Type or Print)
a. (First) BOBBY
b. (Middle) C.
c. (Last) KEEN

4. DATE OF DEATH (Month) (Day) (Year) October 16, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH August 4, 1934
9. AGE (In years last birthday) 33 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Nampa Food Center 26
10b. KIND OF BUSINESS OR INDUSTRY Groceries
11. BIRTHPLACE (State or foreign country) Clifton Hill, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jasper Cecil Keen — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Vera Lee Dodd — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 489 38 1424
17. INFORMANT'S OWN SIGNATURE Shirley J. Keen — ADDRESS Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 178X Bronchial - pneumonia [redacted] — INTERVAL BETWEEN ONSET AND DEATH 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Embryonal Ca of Rt Testis
DUE TO (c) Carcinomatosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1966 *to* Oct 16, 1967 *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at* 12:58A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 450 (Degree or title) MD 1
23b. ADDRESS 723 Roosevelt
23c. DATE SIGNED 10/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE Oct. 17, 1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Nanyon County (State) Idaho

DATE REC'D BY LOCAL REG. Oct. 19, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Mesenbrink
LICENSE NO. E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4437
Local Reg. No. 126
Reg. Dist. No. 360

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 031 Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) 1519 Rochester

3. NAME OF DECEASED (Type or Print)
a. (First) Roy
b. (Middle) W
c. (Last) Gidley

4. DATE OF DEATH (Month) 10 (Day) 16 (Year) 67

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Aug. 16, 1886
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months 2 Days 0 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian 06
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Mt. Vernon, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Darwin Gidley — BIRTHPLACE Mt. Vernon, Kan.
14. MOTHER'S MAIDEN NAME Ella Pierce — BIRTHPLACE Champaign, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 519-03-0644-A
17. INFORMANT'S OWN SIGNATURE Howard W. Gidley — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pt. cerebral artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH 30 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) hypertension —
DUE TO (c) arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-16, 1967, *to* 10-16, 1967, *that I last saw the deceased alive on* 10-16, 1967, *and that death occurred at* 6:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 166 (Degree or title) — **23b. ADDRESS** Caldwell Ida — **23c. DATE SIGNED** 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/19/67
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Oct. 17, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Lucy M. Flahiff — **LICENSE NO.** E 393
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 12 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4438
Local Reg. No. 138
Reg. Dist. No. 360

RECEIVED
NOV 2 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 — 317
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place): 17 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 142
b. COUNTY: ~~Ada~~ Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location): 124 14th Ave. No.

3. NAME OF DECEASED (Type or Print)
a. (First): LEWIS
b. (Middle): F.
c. (Last): BEASLEY

4. DATE OF DEATH (Month) (Day) (Year): Oct. 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 8, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Custodian 06
10b. KIND OF BUSINESS OR INDUSTRY: Nampa School Dist.
11. BIRTHPLACE (State or foreign country): Jamestown, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frederick Beasley — BIRTHPLACE: Ill.
14. MOTHER'S MAIDEN NAME: Maggie Edwards — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-18-5433
17. INFORMANT'S OWN SIGNATURE: X Mabel Beasley — ADDRESS: 124-14 Ave No Nampa

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

444X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Hypostatic pneumonia	2 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Essential hypertension	10 yrs
DUE TO (c)	Generalized arteriosclerosis	10 yrs
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes mellitus	10 yrs

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 2, 1967, *to* Oct 17, 1967, *that I last saw the deceased alive on* Oct 17, 1967, *and that death occurred at* 2:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. B. Ball M.D. 766 (Degree or title) 1
23b. ADDRESS: 824-17th Ave S, Nampa.
23c. DATE SIGNED: 10/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Oct. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 30, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: G. W. Waters — LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 26 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4439
Local Reg. No. 133
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memo. Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1921 Idaho St.

3. NAME OF DECEASED (Type or Print)
a. (First) Ethel
b. (Middle) A.
c. (Last) LaFond

4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Nov. 8, 1878
9. AGE (In years last birthday) 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Sterling Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Haney — BIRTHPLACE Unk.
14. MOTHER'S MAIDEN NAME Elizabeth Holland — BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) -----
16. SOCIAL SECURITY NO. 518-24-7139A
17. INFORMANT'S OWN SIGNATURE + Mrs. John Davis — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9030

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture of the right hip — INTERVAL BETWEEN ONSET AND DEATH 3 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) advanced age
DUE TO (c) Shock & senile dementia past operatively

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. got steadily worse despite blood transfusion & supportive treatment

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE XX (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01
21c. (CITY, TOWN, OR TOWNSHIP) 13 Caldwell — (COUNTY) 141 Canyon — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) a m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Tripped on rug at home

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 10-17, 1967, *that I last saw the deceased alive on* 10-17, 1967, *and that death occurred at* 24 *m., from the causes and on the date stated above.*

23a. SIGNATURE Charles E Kimick 280 (Degree or title) MD
23b. ADDRESS 1819 Ellis St Caldwell Idaho
23c. DATE SIGNED 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Oct. 23, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Merville D. Davis
LICENSE NO. E-399

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: AUG 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-9870 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4440
Local Reg. No. 136
Reg. Dist. No. 360

BIRTH NO.

NOV 2 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Canyon 142 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 142

b. COUNTY: Canyon

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa

d. STREET ADDRESS (If rural, give location): 304 Nectarine

3. NAME OF DECEASED (Type or Print)

a. (First): -

b. (Middle): -

c. (Last): BUTCHART

4. DATE OF DEATH: (Month) (Day) (Year): October 19, 1967

5. SEX: M

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): INFANT

8. DATE OF BIRTH: October 19, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours: 4 | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ------- 02

10b. KIND OF BUSINESS OR INDUSTRY: -------

11. BIRTHPLACE (State or foreign country): Nampa Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ronald E. Butchart

BIRTHPLACE: Nampa, Idaho

14. MOTHER'S MAIDEN NAME: Sandra Kahl

BIRTHPLACE: Morris, Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): --------

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --------

17. INFORMANT'S OWN SIGNATURE: X [signature] ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

776X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:10A. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 345 (Degree or title)

23b. ADDRESS: 619 S Canyon

23c. DATE SIGNED: Oct 23, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/23/67

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens

24d. LOCATION (City, town, or county) (State): Canyon County, Idaho

DATE REC'D BY LOCAL REG.: Oct. 26, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: [signature] LICENSE NO.: E-496

FIRM NAME: Aisip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4441
Local Reg. No. 140
Reg. Dist. No. 360

Certificate of Death

RECEIVED NOV 2 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): P.O. Box 325

3. NAME OF DECEASED (Type or Print)
a. (First): Kura
b. (Middle):
c. (Last): Shinya

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1967

5. SEX: Female
6. COLOR OR RACE: Japanese
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 21, 1893
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Takaieka, Japan
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-34-2982A
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Maretha Nishitani

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBROVASCULAR HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 7 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CEREBRAL ARTERIOSCLEROSIS — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 21, 1967, *to* Oct 21, 1967, *that I last saw the deceased alive on* Oct 21, 1967, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Donald D. Price 424 (Degree or title) MD 1
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 10/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Oct. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 30, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D. Davis
LICENSE NO.: E-395

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4442
Local Reg. No. 144
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 8 1967 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Canyon 142 138

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa

c. LENGTH OF STAY (in this place): 38Yrs

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 142

b. COUNTY: Canyon

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 2341

d. STREET ADDRESS (If rural, give location): 812½ 2nd ST. NORTH

3. NAME OF DECEASED (Type or Print)

a. (First): Nellie

b. (Middle): Ethel

c. (Last): Carter

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 4 Divorced

8. DATE OF BIRTH: May 21, 1890

9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Lathrop, Clinton, Mo.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: U.D. Kindred — BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Maria Jane Heath — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-24-8088

17. INFORMANT'S OWN SIGNATURE: Della Jane Schroeder — ADDRESS: Payette, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4330

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Standstill

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) ASHD c̄ Complete

DUE TO (c) Heart Block Adams Stokes Syndrome 7 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1963, *to* Oct, 1967, *that I last saw the deceased alive on* Oct 5, 1967, *and that death occurred at* 5:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 115 (Degree or title)

23b. ADDRESS: Nampa Idaho

23c. DATE SIGNED: 10/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: 10-28-67

24c. NAME OF CEMETERY OR CREMATORY: Rosedale

24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: Nov. 6, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Donald F Brown

LICENSE NO.: E-408

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Ontario Chapel of the Roses

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4443
Local Reg. No. 139
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 8 1967 Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 44 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 5

3. NAME OF DECEASED (Type or Print)
a. (First): Yutaka
b. (Middle):
c. (Last): Tamura

4. DATE OF DEATH: (Month) (Day) (Year): Oct. 21, 1967

5. SEX: Male

6. COLOR OR RACE: Japanese

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 29, 1918

9. AGE (In years last birthday): 49
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Toyosaburo Tamura
BIRTHPLACE: Japan

14. MOTHER'S MAIDEN NAME: Tsutano Sumihiro
BIRTHPLACE: Japan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-42-5935

17. INFORMANT'S OWN SIGNATURE ADDRESS
x Ruth Tamura

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CORONARY ARTERIOSCLEROSIS — 6 mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1/17, 1966, *to* 10/21, 1967, *that I last saw the deceased alive on* 10/20, 1967, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Donald D. Price 424 (Degree or title) MD
23b. ADDRESS: Caldwell Ida
23c. DATE SIGNED: 11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 24, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 7, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D. Davis
LICENSE NO.: E-399
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 139
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 2 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 5

3. NAME OF DECEASED (Type or Print): a. (First) Yutaka; b. (Middle); c. (Last) Tamura

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1967

5. SEX: Male

6. COLOR OR RACE: Japanese

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: April 29, 1918

9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Toyosaburo Tamura — BIRTHPLACE: Japan

14. MOTHER'S MAIDEN NAME: Tsutano Sumihiro — BIRTHPLACE: Japan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-42-5935

17. INFORMANT'S OWN SIGNATURE ADDRESS: Mrs. Yutaka Tamura

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARDIAC ARRHYTHMMIA — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) MYOCARDIAL INFARCTION — 2 mos.
DUE TO (c) CORONARY ARTERIOSCLEROSIS — 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July, 1966, *to* Oct., 1967, *that I last saw the deceased alive on* Oct 20, 1967, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald D Price MD
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 10/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 24, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Oct. 30, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D Davis
LICENSE NO.: E-399
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

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PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

APR 16 1997

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Amended November 29, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4444
Local Reg. No. 156
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 14
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print): a. (First) Tom; b. (Middle) A; c. (Last) Tenison

4. DATE OF DEATH: (Month) (Day) (Year): October 22, 1967

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 23, 1900

9. AGE (In years last birthday): 66
IF UNDER 1 YEAR: Months 9; Days 29
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Chandler, Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ben Tenison
BIRTHPLACE: Hennison Co. Texas

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 453-30-8891

17. INFORMANT'S OWN SIGNATURE: Agnes Tenison
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Tubercular Pneumonia - terminal — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Undiscovered previous focus - - - - — with miliary extension to liver & spleen — ? X Ray negative
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic vascular disease — years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1958, 19__, *to* Oct 22, 19 67, *that I last saw the deceased alive on* Oct 22, 19 67, *and that death occurred at* 1:15 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): I. W. Kellogg, M.D. 275
23b. ADDRESS: 1201 S. Kimball, Caldwell, Ida.
23c. DATE SIGNED: Nov 6, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 10, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

AFFIDAVIT TO CORRECT A RECORD

STATE FILE NO.

☐ BIRTH ☒ DEATH ☐ MARRIAGE

REGISTRATION DISTRICT NO. 360 REGISTRAR'S NUMBER 156

REGISTRANT INFORMATION SEE INSTRUCTIONS ON REVERSE

1a. FIRST NAME	1b. MIDDLE NAME	1c. LAST NAME
Tom	A	Tenison

2. PLACE OF OCCURRENCE—CITY OR COUNTY	3. DATE OF EVENT	4. DATE ORIGINAL FILED
Caldwell	Oct. 22, 1967	Nov. 14, 1967

5. NAME OF FATHER	6. MAIDEN NAME OF MOTHER
Ben Tenison	Unk.

STATEMENT OF CORRECTIONS

7. ITEM NUMBER	8A. FACTS EXACTLY AS STATED ON THE ORIGINAL RECORD	8B. FACTS AS THEY SHOULD HAVE BEEN STATED ON THE ORIGINAL AT THE TIME OF OCCURRENCE.
	Dec. 23, 1888	Dec. 23, 1900

WHY IS CHANGE NECESSARY?

9. According to family records, the age was mistated.

FIRST SUPPORTING AFFIDAVIT

10. I, THE AFFIANT, HAVING PERSONAL KNOWLEDGE OF THE ABOVE FACTS AND RELATED AS daughter TO THE REGISTRANT NAMED IN ITEM 1 OF THIS DOCUMENT, DO SOLEMNLY SWEAR THAT THE FACTS LISTED UNDER ITEM 8A. ABOVE, WERE INCORRECTLY STATED AT THE TIME OF THE EVENT, AND TO MAKE THE ORIGINAL RECORD A TRUE STATEMENT OF THE FACTS AS THEY EXISTED AT THE TIME OF OCCURRENCE. THE AMENDMENTS LISTED UNDER ITEM 8B. ABOVE, ARE NECESSARY.

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS 21st DAY OF November 67

SIGNATURE OF AFFIANT ▶ Mary O August — AGE OF AFFIANT 44

ADDRESS OF AFFIANT—STREET ADDRESS 517 E. Fourth St.

SIGNATURE AND SEAL OF NOTARY PUBLIC ▶ Mildred Crawford

ADDRESS OF AFFIANT—CITY AND STATE Stockton, Calif.

NOTARY PUBLIC IN AND FOR THE COUNTY OF San Joaquin STATE OF Calif. 19 69

MY COMMISSION EXPIRES Sept 4

SECOND SUPPORTING AFFIDAVIT

11. I, THE AFFIANT, HAVING PERSONAL KNOWLEDGE OF THE ABOVE FACTS AND RELATED AS _____ TO THE REGISTRANT NAMED IN ITEM 1 OF THIS DOCUMENT, DO SOLEMNLY SWEAR THAT THE FACTS LISTED UNDER ITEM 8A. ABOVE, WERE INCORRECTLY STATED AT THE TIME OF THE EVENT, AND TO MAKE THE ORIGINAL RECORD A TRUE STATEMENT OF THE FACTS AS THEY EXISTED AT THE TIME OF OCCURRENCE. THE AMENDMENTS LISTED UNDER ITEM 8B. ABOVE, ARE NECESSARY.

SUBSCRIBED AND SWORN TO BEFORE ME ON THIS _____ DAY OF _____ 19____

SIGNATURE OF AFFIANT ▶ — AGE OF AFFIANT

ADDRESS OF AFFIANT—STREET ADDRESS

SIGNATURE AND SEAL OF NOTARY PUBLIC ▶

ADDRESS OF AFFIANT—CITY AND STATE

NOTARY PUBLIC IN AND FOR THE COUNTY OF _____ STATE OF _____

MY COMMISSION EXPIRES _____ 19____

FOR USE OF STATE REGISTRAR

12.

DATE ACCEPTED AND FILED

STATE REGISTRAR ▶

STATE OF CALIFORNIA

REV. 1-1-52 FORM VS-24

DEPARTMENT OF PUBLIC HEALTH

INSTRUCTIONS

(1) Check the type of certificate to be corrected: Birth, Death or Marriage.

(2) Enter the Registration District Number and Registrar's Number in the spaces provided at the top of this form. These numbers MUST be correct or the affidavit can not be accepted. They can be found on a copy of the original certificate.

(3) Complete the information in Spaces 1a, 1b, 1c, 2, 3 and 4 AS IT APPEARS ON THE ORIGINAL CERTIFICATE even if incorrect.

(4) In the column under Item 7, enter the number or numbers of the incorrect item or items on the original record and in the lines under Item 8a enter the information as it is now incorrectly stated.

(5) Opposite each of the incorrect items list under 8b the information as it should have been stated AT THE TIME OF OCCURRENCE OF THIS PARTICULAR EVENT.

(6) In Space 9, explain briefly why the above change or changes are necessary.

(7) READ THE AFFIDAVIT WHICH IS TO BE SWORN TO AND SIGNED IN SPACES 10 AND 11. TWO different people who can swear to the correctness of the above changes must sign the supporting affidavits in the presence of a Notary Public or officer authorized to administer oaths who will witness, sign and seal each affidavit. The relation of each affiant to the registrant must be stated such as "physician," "mother," "father," "sister," "brother," "nurse," "attorney," "friend," etc., and the age of the affiant at the time of signing must be given. The registrant, if of legal age, may complete ONE of the supporting affidavits.

(8) DO NOT write in Space 12. (This is reserved for use by State Registrar.)

(9) When properly completed, signed and witnessed, return the form to the State Registrar of Vital Statistics, 631 J Street, Sacramento, California.

(10) If acceptable the affidavit will be filed with the original record and a certified copy may be obtained from the County Recorder, Local Registrar or State Registrar of Vital Statistics.

State File No. 4444
Local Reg. No. 156
Reg. Dist. No. 360

Certificate of Death

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)
a. (First): TOM
b. (Middle): A
c. (Last): TENISON

4. DATE OF DEATH (Month) 10 (Day) 22 (Year) 67

5. SEX: M
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec. 23, 1888
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months 9, Days 29 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Chandler, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ben Tenison — BIRTHPLACE: Hennison Co Texas
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 453-30-8891
17. INFORMANT'S OWN SIGNATURE: X [signature] — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Tubercular Pneumonia — terminal with miliary extension to liver + spleen — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): undercovered previous focus — ? X Ray negative
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic vascular disease — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1958, 19__, *to* Oct 22, 1967, *that I last saw the deceased alive on* Oct 22, 1967, *and that death occurred at* 1:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] — (Degree or title): MD
23b. ADDRESS: 1201 S Kimball Caldwell Id.
23c. DATE SIGNED: 6 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/26/67
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 10, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff — LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 14 1967

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4445
Local Reg. No. 145
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 8 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: CANYON 142 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
LENGTH OF STAY (in this place): 23 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 143
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 144 1ST ST. NO. EXT.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
PETER	(NMN)	ALAVARADO	10	23	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	MEXICAN	MARRIED 3	JAN 18, 1901	66	9	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED MINISTER 78	MINISTERY	SALTELLO: COAH, MEXICO	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
PALINARIO ALVARADO	MEXICO	DAMIANA PEDRAZO	MEXICO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	1921 1922	520-20-7229	X Esther A. Alvarado	Nampa, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cancer uterus — INTERVAL BETWEEN ONSET AND DEATH: 6 Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-24- , 19 67 , *to* 10-23- , 19 67 , *that I last saw the deceased alive on* 10-23- , 19 67 , *and that death occurred at* 4:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard C. Jungen M.D. 666 1	619 So. Canyon, Nampa, Idaho	11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	10-26-1967	HILLCREST MEMORIAL	CANYON IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 6, 1967	Mrs. Martina Walmsley	M. B. Shepherd	423

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4446
Local Reg. No. 143
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 112
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 12 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho State School & Hospital 052

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) James b. (Middle) Theodore c. (Last) Edwards III

4. DATE OF DEATH: (Month) October (Day) 23 (Year) 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: June 7, 1951

9. AGE (In years last birthday): 16
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 03

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Oregon

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Theodore Edwards, Jr. BIRTHPLACE: Nampa, Idaho

14. MOTHER'S MAIDEN NAME: Marjory McCutchan BIRTHPLACE: Hood River, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Evelyn Fox, ARNP ADDRESS: Nampa

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 493X pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*: constructive osteomyelitis — 16 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July 1, 19 63 *to* October 22 19 67, *that I last saw the deceased alive on* October 22, 1967, *and that death occurred at* 1:33 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 345 (Degree or title) M.D.

23b. ADDRESS: Nampa, Idaho

23c. DATE SIGNED: Oct 26, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: 10-30-67

24c. NAME OF CEMETERY OR CREMATORY: KONIERLAWN CEMETERY

24d. LOCATION (City, town, or county) (State): NAMPA IDAHO

DATE REC'D BY LOCAL REG.: Nov. 2, 1967

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature] LICENSE NO. 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4447
Local Reg. No. 137
Reg. Dist. No. 360

RECEIVED NOV 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 14 / 000
b. CITY OR TOWN: Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Memorial Hospital 05/

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 370
b. COUNTY: Owyhee
c. CITY OR TOWN: Homedale
d. STREET ADDRESS (If rural, give location): Rt. # 1, Box 102

3. NAME OF DECEASED (Type or Print): a. (First) Leonard b. (Middle) J. c. (Last) Rheuby

4. DATE OF DEATH (Month) (Day) (Year): Oct. 23, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 5, 1906

9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months 4, Days 18 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Satanta, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew J. Rheuby — BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Lois Jane Minton — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-09-0207

17. INFORMANT'S OWN SIGNATURE: Beatrice Rheuby — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5271 Pulmonary Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Sept 30, 1967, *to* Oct 23, 1967, *that I last saw the deceased alive on* Oct 23, 1967, *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 570 (Degree or title) MD / **23b. ADDRESS**: Caldwell Ida. **23c. DATE SIGNED**: 10-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Oct. 27, 1967

24c. NAME OF CEMETERY OR CREMATORY: Weseman Cemetery

24d. LOCATION (City, town, or county) (State): Orfino, Idaho

DATE REC'D BY LOCAL REG.: Oct 30, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Merville D Davis

LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4448
Local Reg. No. 141
Reg. Dist. No. 360

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 14 NOV 6 1967 600
b. CITY OR TOWN Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 011 b. COUNTY Ada
c. CITY OR TOWN Boise
d. STREET ADDRESS (If rural, give location) 4515 Fairmont Place

3. NAME OF DECEASED (Type or Print): a. (First) Richard b. (Middle) A. c. (Last) Anderson

4. DATE OF DEATH (Month) (Day) (Year): October 24, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 29, 1905
9. AGE (In years last birthday): 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Traffic Manager of U.P. R.R. Boise, Ida.
10b. KIND OF BUSINESS OR INDUSTRY: 10
11. BIRTHPLACE (State or foreign country): Yakima, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William A. Anderson
BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Mary Alice Schaffer
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): War II 4
16. SOCIAL SECURITY NO.: 519-07-0357
17. INFORMANT'S OWN SIGNATURE: x Nora Byrd Thompson
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarct
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary sclerosis
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 3 Days.

II. OTHER SIGNIFICANT CONDITIONS: cirrhosis liver
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 22, 1967, *to* Oct 24, 1967, *that I last saw the deceased alive on* Oct 24, 1967, *and that death occurred at* 9:[illegible] *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] MD (Degree or title)
23b. ADDRESS: Caldwell Ida
23c. DATE SIGNED: 10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 27, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 1, 1967
REGISTRAR'S SIGNATURE: [signature] M D
25. EMBALMER: Merville D Davis
LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1967

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 8 1967 Bureau of Vital Statistics

State File No. 4449
Local Reg. No. 146
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 001
b. CITY OR TOWN Nampa
DURATION OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 140 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kuna Rural
d. STREET ADDRESS (If rural, give location) R# 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jessie	M. Haber	Owen	October 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	March 2, 1914	53				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	American Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Benjamin Jones	Malta, Idaho	Minnie Rose	American Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 24 2933	William L. Owen	Kuna, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Breast Cancer
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-31-66	Ductal Carcinoma Breast	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan. 4, 1960 *to* Oct, 1967, *that I last saw the deceased alive on* Oct 25, 1967, *and that death occurred at* 9:20P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hayden Olsen MD 115	Nampa Ida	11-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 30, 1967	Kohlerlawn Cemetery	Nampa Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 6, 1967	Mrs. Martina Walmsley	[signature]	E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4450
Local Reg. No. 147
Reg. Dist. No. 360

RECEIVED
NOV 8 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 14/Canyon 009
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 316
b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Marsing
d. STREET ADDRESS (If rural, give location) Rt. # 1, Box 131

3. NAME OF DECEASED (Type or Print)
a. (First) Ethel
b. (Middle) E.
c. (Last) Krivanec

4. DATE OF DEATH (Month) (Day) (Year) Oct. 26, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 6, 1919

9. AGE (In years last birthday) 48
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Gilford, Montana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Francis O. Saul
BIRTHPLACE Ohio

14. MOTHER'S MAIDEN NAME Philiphine Brown
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-22-6116

17. INFORMANT'S OWN SIGNATURE x Bert Krivanec
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Breast
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-14-66, 19___, *to* 10-26-67, 19___, *that I last saw the deceased alive on* 10-26-67, 19___, *and that death occurred at* 6:05P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 178 MD

23b. ADDRESS 222 East Elm--Caldwell, Idaho

23c. DATE SIGNED 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 31, 1967

24c. NAME OF CEMETERY OR CREMATORY Marsing-Homedale Cemetery

24d. LOCATION (City, town, or county) Marsing, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 6, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Kenneth E. Spence

LICENSE NO. E-395

FIRM NAME Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4451
Local Reg. No. 142
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL NAMPA
c. LENGTH OF STAY (in this place): TRANSIT
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): SOUTH OF NAMPA 12th AVE 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 142 b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 208 FERN

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MATHEW	(nmn)	PULSCHER	OCT. 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED 3	APRIL 29, 1894	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
RETIRED RANCHER 04	RANCHING	ALBANY COUNTY, WYOMING	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOHN PULSCHER	GERMANY	KATHERINE NAU	SWITZERLAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	521-44-7364	X Mrs Jessie E Pulscher	NAMPA

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-22- *,* 19 66 *, to* 10-26- *,* 19 67 *, that I last saw the deceased alive on* 7-31- *,* 19 67 *, and that death occurred at* 11:45A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard C. Jones 666	MD	NAMPA, IDAHO	10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL 3	10-28-67	GREEN HILL CEMETERY	LARAMIE, WYOMING

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 2, 1967	C. Hoge	M B Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 14 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4452
Local Reg. No. 150
Reg. Dist. No. 360

RECEIVED NOV 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakley's Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon 141
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 1909 Cleveland Blvd

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Joanna	H.	Champlin	Oct. 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	July 7, 1870	97				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Morgan, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jonathan Hemenway — BIRTHPLACE: Vermont
14. MOTHER'S MAIDEN NAME: Joanna W. Brown — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 519-58-9464T
17. INFORMANT'S OWN SIGNATURE x Maud C White. ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH: many years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Parkinsons disease — many years; Degenerative osteoarthritis — many years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1954 *to* October 27 1967, *that I last saw the deceased alive on* Oct 27, 1967, *and that death occurred at* 9:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
S M Kellogg 275 MD	1201 S. Kimball Caldwell Idaho	6 Nov. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 31, 1967	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 8, 1967	Mrs. Martina Walmsley	Kenneth E Spence	E-395

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4453
Local Reg. No. 155
Reg. Dist. No. 360

Certificate of Death

RECEIVED
NOV 13 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 409
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 9 Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 380
b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): Route #1 2 Mi West of N.P.

3. NAME OF DECEASED (Type or Print)
a. (First): BERNARD
b. (Middle): GEORGE
c. (Last): ANDERSON

4. DATE OF DEATH (Month) (Day) (Year): October 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: November 3, 1896
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months – Days – IF UNDER 24 HRS.: Hours – Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY: Real Estate
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jim Anderson — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Jane Dalton — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WWI & WWII 4
16. SOCIAL SECURITY NO.: 518-36-0828
17. INFORMANT'S OWN SIGNATURE: Mrs. Bertha Anderson — ADDRESS: New Plymouth, Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): arteriosclerotic Heart disease — INTERVAL BETWEEN ONSET AND DEATH: 12 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Upper Gastrointestinal Bleeding — 4 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-4-55, 19__, *to* 10-28-67, 19__, *that I last saw the deceased alive on* 10-28-67, 19__, *and that death occurred at* 6:15P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Nuhlenm 250 1
23b. ADDRESS: 222 East Elm—Caldwell, Idaho
23c. DATE SIGNED: 11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-burial 3
24b. DATE: Oct. 31, 1967
24c. NAME OF CEMETERY OR CREMATORY: Park View Cemetery
24d. LOCATION (City, town, or county) (State): New Plymouth Idaho

DATE REC'D BY LOCAL REG.: Nov. 10, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shaffer Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under it DEC to 4 1967 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures DEC 5 1967 of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 11 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4454
Local Reg. No. 157
Reg. Dist. No. 360

Certificate of Death

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D. O. A. Caldwell Memorial Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) Route #6

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPHINE
b. (Middle)
c. (Last) LANDA

4. DATE OF DEATH (Month) 10 (Day) 30 (Year) 67

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH March 28, 1937
9. AGE (In years last birthday) 30 — IF UNDER 1 YEAR: Months 7, Days 2 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper 19
10b. KIND OF BUSINESS OR INDUSTRY I D. Store
11. BIRTHPLACE (State or foreign country) Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Sabino Landa — BIRTHPLACE Spain
14. MOTHER'S MAIDEN NAME Sabina Gortia — BIRTHPLACE Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 518-44-5600
17. INFORMANT'S OWN SIGNATURE Sabino Landa — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe traumatic rupture of liver with massive hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Multiple rib fractures right lateral with rupture & lacerations of right lung — immediate
DUE TO (c) also with massive hemorrhage & tension pneumothorax

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Patient died immediately following an auto accident DOA at Caldwell Memorial Hospital

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1955, *to* Present, 19___, *that I last saw the deceased alive on* 10-1, 1967, *and that death occurred at* 7:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Charles E Kerrick — 280 (Degree or title) MD 1
23b. ADDRESS 1819 Ellis St Caldwell Idaho
23c. DATE SIGNED 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 11/2/67
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 10, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Leonard C. Flahiff
LICENSE NO. E481

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Patient was riding in right front seat & car was struck violently by an on coming car. She received sever blow to right lateral chest & abdomen. She spoke a few words then groaned a few minutes and was dead by time ambulance could deliver her to the hospital. T E Kenrick MD

State File No. 4455
Local Reg. No. 148
Reg. Dist. No. 360

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon NOV 8 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (If not in hospital) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa Rural
d. STREET ADDRESS (If rural, give location) Rural Route #2

3. NAME OF DECEASED (Type or Print)
a. (First) Laura
b. (Middle)
c. (Last) Hay

4. DATE OF DEATH (Month) (Day) (Year) Oct. 31,1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Aug. 22,1872.
9. AGE (In years last birthday) 95 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Monterey, California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Eugene Ira McKean — BIRTHPLACE Oregon
14. MOTHER'S MAIDEN NAME Isadora Canfield — BIRTHPLACE California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 530 22 1206 A
17. INFORMANT'S OWN SIGNATURE Mary Lee Wood — ADDRESS Nampa

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) atherosclerotic cerebral vascular disease — INTERVAL BETWEEN ONSET AND DEATH 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pyelonephritis — 2 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-15-, 19 64, *to* 10-31-67, 19 ___, *that I last saw the deceased alive on* 10-30-, 19 67, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE Robert E Hay MD 217 (Degree or title)
23b. ADDRESS 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED 11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Nov. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Winnemucca, Nevada

DATE REC'D BY LOCAL REG. Nov.6,1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Mesenbrink
LICENSE NO. E-487

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4456
Local Reg. No. 9
Reg. Dist. No. 520-521

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Caribou 150 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caribou County Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 150
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bancroft
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Beatrice Lloyd Hatch

4. DATE OF DEATH (Month) (Day) (Year): October 3, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Dec. 1, 1899
9. AGE (In years last birthday): 67 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Wellsville, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME BIRTHPLACE: William T. Lloyd
14. MOTHER'S MAIDEN NAME BIRTHPLACE: Sarah Myers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE ADDRESS: [signature] Bancroft, Idaho

18. CAUSE OF DEATH 260 X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes mellitus — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 Sept, 1967, *to* 3 Oct, 1967, *that I last saw the deceased alive on* 2 Oct, 1967, *and that death occurred at* 12:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 226 MD
23b. ADDRESS: Grace, Idaho
23c. DATE SIGNED: 6 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/6/67
24c. NAME OF CEMETERY OR CREMATORY: Bancroft Cemetery
24d. LOCATION (City, town, or county) (State): Bancroft, Idaho

DATE REC'D BY LOCAL REG.: 10-6-67
REGISTRAR'S SIGNATURE: Darhl Cheinett
25. EMBALMER: Theodore S. Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4457
Local Reg. No. 11
Reg. Dist. No. 520-521

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

OCT 24 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Caribou 150 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
c. LENGTH OF [illegible] (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 150
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First): ORlaNDo
b. (Middle): William
c. (Last): Wells

4. DATE OF DEATH (Month) (Day) (Year): Oct 11 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 15, 1891
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Wellsville, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard R. Wells — BIRTHPLACE: Maryland
14. MOTHER'S MAIDEN NAME: HaNNah JoNes — BIRTHPLACE: Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 519-01-4866
17. INFORMANT'S OWN SIGNATURE: Mrs. O. W. Wells — ADDRESS: Soda Springs Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Asthma & Emphysema — INTERVAL BETWEEN ONSET AND DEATH: 20 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Seen, after death, *that I last saw the deceased* [illegible] *on* Oct 11, 1967 *and that death occurred at* 2:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Allen H. Tyrst — 534 (Degree or title): MD
23b. ADDRESS: Soda Springs, Ida
23c. DATE SIGNED: 10/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Oct. 14 1967
24c. NAME OF CEMETERY OR CREMATORY: Montpelier Cemetery
24d. LOCATION (City, town, or county) (State): Montpelier Idaho

DATE REC'D BY LOCAL REG.: 10-20-67
REGISTRAR'S SIGNATURE: Darhl Cheirrett
25. EMBALMER: Nile Matthews — LICENSE NO.: E359

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Matthew Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4458
Local Reg. No. 10
Reg. Dist. No. 520-521

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

OCT 19 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Caribou 150 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs Rural
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 20 mi Nth of Soda Springs 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls,
d. STREET ADDRESS (If rural, give location): 339 6th Ave. West

3. NAME OF DECEASED (Type or Print)
a. (First): KUICHI
b. (Middle):
c. (Last): NAKAMURA

4. DATE OF DEATH (Month) 10 (Day) 12 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: Japanese
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: 12-4-1886
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Heroshima-Ken, Japan
12. CITIZEN OF WHAT COUNTRY?: Japan

13. FATHER'S NAME: UNKNOWN — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: UNKNOWN — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-22-0737
17. INFORMANT'S OWN SIGNATURE: Guy Matsuoka — ADDRESS: 150-No. Wash Twin Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushing injury to chest — INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): County Road 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 150 **(STATE)**: Soda Springs, Caribou, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-12-67 5 P.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Car wheel

22. *I hereby certify that I attended the deceased from* Seven after death *19*__, *to* __, *19*__, *that I last saw the deceased* ~~*alive*~~ *on* Oct 12, 1967, *and that death occurred at* 5P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Albert L. Pigott 534 (Degree or title) MD
23b. ADDRESS: Soda Springs, Ida
23c. DATE SIGNED: 10/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 10-21-67
24c. NAME OF CEMETERY OR CREMATORY: Allorest Creamatory
24d. LOCATION (City, town, or county) (State): Ogdon, Utah

DATE REC'D BY LOCAL REG.: 10-16-67
REGISTRAR'S SIGNATURE: Darhl Cherrett
25. EMBALMER: Theodore S Allen
LICENSE NO.: E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 27 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4459
Local Reg. No. 13
Reg. Dist. No. 520-521

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 150
a. COUNTY Caribou 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caribou County Hospital 069

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 150
b. COUNTY Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bancroft
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Ammon Call Hatch
b. (Middle)
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) October 21, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH June 26, 1887
9. AGE (In years last birthday) 80 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-retired 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Chesterfield, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME William Hatch — BIRTHPLACE Bountiful, Utah
14. MOTHER'S MAIDEN NAME Hannah Call — BIRTHPLACE Bountiful, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE A. Paul Hatch — ADDRESS Bancroft, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1790 Adenocarcinoma of penis — INTERVAL BETWEEN ONSET AND DEATH 2 years.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1965, *to* Oct 21, 1967, *that I last saw the deceased alive on* Oct 21, 1967 *and that death occurred at* 11:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE Allen H. Tyrell 534 (Degree or title) MD
23b. ADDRESS Soda Springs, Idaho
23c. DATE SIGNED 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/25/67
24c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery
24d. LOCATION (City, town, or county) (State) Chesterfield, Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE Darhl Cheirrett
25. EMBALMER Theodore S Allen
LICENSE NO. E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4460
Local Reg. No. 12
Reg. Dist. No. 520-521

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Caribou 150 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 031 b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 655 So. 6th

3. NAME OF DECEASED (Type or Print) a. (First) DAVID b. (Middle) LEE c. (Last) TREGO

4. DATE OF DEATH (Month) (Day) (Year) Oct. 22, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Jine 1, 1952
9. AGE (In years last birthday) 15 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Douglas W. Trego BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Patricia Cronin BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-62-9667
17. INFORMANT'S OWN SIGNATURE ADDRESS Pocatello, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

9198

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Mountains while hunting
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 150 (STATE) Chesterfield, Caribou, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct. 22, 1967
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? While hunting deer

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Theodore S Allen 583 (Degree or title) Coroner
23b. ADDRESS Soda Springs Idaho
23c. DATE SIGNED 10/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-2[illegible]-67
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) (State) Pocatello, Idaho

DATE REC'D BY LOCAL REG. 10-31-67
REGISTRAR'S SIGNATURE Darl Cherrett
25. EMBALMER John P. Gomez
LICENSE NO. E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED OCT 25 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4461
Local Reg. No. 1757
Reg. Dist. No. 470

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia 16 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 348
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
d. STREET ADDRESS (If rural, give location): 1151 18th.

3. NAME OF DECEASED (Type or Print): a. (First) Lewis b. (Middle) Alton c. (Last) Hamilton

4. DATE OF DEATH (Month) (Day) (Year): Sept. 19, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Mar. 23, 1896

9. AGE (In years last birthday): 71
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Ottumwa, Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John A. Hamilton
BIRTHPLACE: Cadena, Ohio

14. MOTHER'S MAIDEN NAME: Anna Rachel McLaughin
BIRTHPLACE: Cadena, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I, 3

16. SOCIAL SECURITY NO.: 518-14-1524

17. INFORMANT'S OWN SIGNATURE: Alice P. Hamilton
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 4-5 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Burley

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 1949 *to* Sept 19, 1967, *that I last saw the deceased alive on* Sept 16, 1967 *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: John F. Davis M.D. 135 (Degree or title)

23b. ADDRESS: Burley Idaho

23c. DATE SIGNED: Oct 25 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 9/22/1967

24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery

24d. LOCATION (City, town, or county) (State): Heyburn, Idaho

DATE REC'D BY LOCAL REG.: Oct 26 1967

REGISTRAR'S SIGNATURE: Ruth A. Pearson

25. EMBALMER: Ruth Lloyd

LICENSE NO.: E 389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 31 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 20 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4462
Local Reg. No. 1755
Reg. Dist. No. 470

RECEIVED OCT 9 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 2½ mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 160 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley, Rural
d. STREET ADDRESS (If rural, give location): 300 W. 100 So.

3. NAME OF DECEASED (Type or Print)
a. (First): Austin
b. (Middle): Emanuel
c. (Last): Hanks

4. DATE OF DEATH (Month) (Day) (Year): Oct. 1, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 1, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Bountiful, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Emanuel Hanks - Gloucester, Eng.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Maralda Willey - Bountiful, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-44-9036
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Edison Hanks - Burley, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 6 months

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Intertrochanteric fracture L. Hip — 3 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 12, 1967, *to* 10-1, 1967, *that I last saw the deceased alive on* 10-1-67, 19__, *and that death occurred at* 10:00Pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Eugene H. Schmitz 239 M.D.
23b. ADDRESS: 1341 Overland Ave., Burley, Ida.
23c. DATE SIGNED: 10-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10/4/1967
24c. NAME OF CEMETERY OR CREMATORY: Syracuse Cemetery
24d. LOCATION (City, town, or county) (State): Syracuse, Utah

DATE REC'D BY LOCAL REG.: Oct. 6 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Garth Harper
LICENSE NO.: E 389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 9 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS By Physician.....

State File No. 4463
Local Reg. No. 1758
Reg. Dist. No. 470

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 160 Cassia 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Malta
c. LENGTH OF STAY (in this place): None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Police Checking Station 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: 555 Yakima
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buena
d. STREET ADDRESS (If rural, give location): Box 151

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Rico Roberto Crane Kleeschulte

4. DATE OF DEATH (Month) (Day) (Year): Oct. 9, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married 1
8. DATE OF BIRTH: Aug. 26, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months 1 Days 13; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 02
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Clayton, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME BIRTHPLACE: James Robert C. Kleeschulte-Missouri
14. MOTHER'S MAIDEN NAME BIRTHPLACE: Paula E. Matthews - St. Louis, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE ADDRESS: James Roberts Kleeschulte

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9248

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crib death

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Probable suffocation
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 160 **(STATE)**: Rural Cassia Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Early AM 10-9-67 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Face down in crib

22. *I hereby certify that I attended the deceased from* Investigated 31, 19__, *to* dealy of, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* early *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leslie L Fillmore MD 165 1
23b. ADDRESS: Box 657 Burley Idaho
23c. DATE SIGNED: 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 10/10/67
24c. NAME OF CEMETERY OR CREMATORY: Tillah, Washington
24d. LOCATION (City, town, or county) (State): Tillah, Washington

DATE REC'D BY LOCAL REG.: Oct. 30 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: J. Barth Payne
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Payne Mortuary

...ir, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4464
Local Reg. No. 1756
Reg. Dist. No. 470

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Cassia 161 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (In this place) 1 hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul
d. STREET ADDRESS (If rural, give location) 1150 west 100 north

3. NAME OF DECEASED (Type or Print)
a. (First) Steven
b. (Middle) Carl
c. (Last) Zunino

4. DATE OF DEATH (Month) (Day) (Year) 10-10-1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Mar 3 1955
9. AGE (In years last birthday) 12 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grade school student
10b. KIND OF BUSINESS OR INDUSTRY 03
11. BIRTHPLACE (State or foreign country) Ely Nevada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Aldo Zunino
BIRTHPLACE Ely Nevada
14. MOTHER'S MAIDEN NAME Joyce Stallard
BIRTHPLACE Yarrington Nevada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Aldo Zunino
ADDRESS Route 2 Paul Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9191

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Wound, gunshot, abdomen
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: less than 1 hour.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 02 Farm
21c. (CITY, TOWN, OR TOWNSHIP) 340 (COUNTY) (STATE) 13 Minidoka County, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-10-67 11 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Shotgun accidentally discharged while child was riding in rear of pickup truck.

22. *I hereby certify that I attended the deceased from* Aug 26, 1963, *to* 10/10/, 1967, *that I last saw the deceased alive on* 10/10/67, 19___, *and that death occurred at* 11 40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert M. Stovall 506 (Degree or title) MD
23b. ADDRESS Paul, Idaho
23c. DATE SIGNED 10/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Oct 13 1967
24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery
24d. LOCATION (City, town, or county) (State) Paul Idaho

DATE REC'D BY LOCAL REG. 10-18-67
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Robert C Walk
LICENSE NO. E 294

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WALK MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

DUTIES:

NOV 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 25 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4465
Local Reg. No. 1759
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 161 Cassia 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 5mdays, 070
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 161 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): Gem Apt.

3. NAME OF DECEASED (Type or Print)
a. (First) b. (Middle) c. (Last): Otto Johanes Paulson

4. DATE OF DEATH (Month) (Day) (Year): Oct 27th. 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single 1
8. DATE OF BIRTH: Oct. 7th. 1885
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Optomitrist 21
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Newry Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ole. R. Paulson. BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Ingevoborg Odeggaard, BIRTHPLACE: Norway Box 284

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519=12-5083
17. INFORMANT'S OWN SIGNATURE: John Paulson ADDRESS: Ellendale Minnesota

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

444X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 8 yr
DUE TO (c) Generalized Arteriosclerosis — 10 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Adenocarcinoma of Prostate — 10 yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-27-60, 19 1, *to* 10-27-67, 19___, *that I last saw the deceased alive on* 10-27-67 19___, *and that death occurred at* 11:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 526 (Degree or title) MD 1
23b. ADDRESS: Burley
23c. DATE SIGNED: 20 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Oct. 30. 1967
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
25. EMBALMER: [signature]
LICENSE NO.: E-460

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BOISE, IDAHO BUREAU OF VITAL STATISTICS,

RECEIVED

OCT 16 1967

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4466
Local Reg. No. 79
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 180 140
b. CITY OR TOWN: Orofino
LENGTH OF STAY (in this place): 40 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Own Home OOU

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 188
b. COUNTY: Clearwater
c. CITY OR TOWN: Orofino
d. STREET ADDRESS (If rural, give location): 324 Kalaspo

3. NAME OF DECEASED (Type or Print): a. (First) ARTHUR b. (Middle) c. (Last) DINNISON

4. DATE OF DEATH: (Month) Oct. (Day) 7 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married 3	Nov. 13, 1890	76		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Clerk-Postmaster 08	US Postal Service	Liberty, Pennsylvania	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Dinnison	Pennsylvania	Anna Guy	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW I 3	519-23-9951	Virginia Dinnison	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute M.I. — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD, severe — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary emphysema — years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June, 1966 *to* Oct 8, 1967, *that I last saw the deceased alive on* Oct 1, 19 67, *and that death occurred at* 3:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	03B	Orofino, Idaho	10-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	October 10, '67	Riverside	Orofino Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
October 13, 1967	June M. Lowell	[signature]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 2 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4467
Local Reg. No. 81
Reg. Dist. No. 210

RECEIVED OCT 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 18
b. CITY OR TOWN: Southwick
c. LENGTH OF STAY IN THIS PLACE: few hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dick's Creek Area 007

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 18
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
d. STREET ADDRESS (If rural, give location): Swayne's Addition

3. NAME OF DECEASED (Type or Print): a. (First) ANTHONY b. (Middle) c. (Last) SHAMION

4. DATE OF DEATH: (Month) Oct. (Day) 9 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	June 6 1907	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Woodsworker 17	Timber	Iron River, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Anthony Shamion	Poland	Sarah Milanoski	Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	379-10-5330	X Lyle A. Stoltzmann	Orofino

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Massive Head & internal injuries — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Logging Accident.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 18 (STATE)
Accident	Dick's Creek 09	Southwick Clearwater Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Oct 9 67 1:15 P.M.		Logging Truck Accident

22. *I hereby certify that I attended the deceased from* Jul 2 *, 19*60*, to* 9 Oct *, 19*67*, that I last saw the deceased alive on* 9 Oct *, 19*67*, and that death occurred at* 1:15 P.M.*, from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	340 M.D.	Orofino Idaho	12 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 13, 1967	L-C Memorial Gardens	Lewiston Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1967	June McConnell	Lyle A. Stoltzmann	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4468
Local Reg. No. 80
Reg. Dist. No. 210

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Clearwater 180
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Clearwater Valley Hosp 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 320
b. COUNTY Lewis 304
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kamiah
d. STREET ADDRESS (If rural, give location) Kamiah, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) OLGA b. (Middle) JOY c. (Last) HANSON

4. DATE OF DEATH (Month) (Day) (Year) October 9, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Sept 5, 1902

9. AGE (In years last birthday) 65
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Fletcher, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Bartlett
BIRTHPLACE Penn.

14. MOTHER'S MAIDEN NAME Laura Carrington
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 05 1648

17. INFORMANT'S OWN SIGNATURE x Clarence W Hansen
ADDRESS Kamiah, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Carcinomatosis, generalized — INTERVAL BETWEEN ONSET AND DEATH 7 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 5, 1967 to Oct 9, 1967, *that I last saw the deceased alive on* Oct 8, 1967, *and that death occurred at* 5:14 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 652 1

23b. ADDRESS Kamiah, Idaho

23c. DATE SIGNED Oct. 17, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/11/1967

24c. NAME OF CEMETERY OR CREMATORY Lewis & Clark Mem. Gds.

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. Oct. 20, 1967

REGISTRAR'S SIGNATURE Irene M. Powell

25. EMBALMER Robert R Hansen Hansen

LICENSE NO. E 433

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4469
Local Reg. No. 82
Reg. Dist. No. 210

BIRTH NO.

RECEIVED OCT 25 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Clearwater 180 412
b. CITY OR TOWN Orofino
(If outside corporate limits, write RURAL and give township)
STATE OF STAY (in this place) 12 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CV Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16
b. COUNTY Clearwater
c. CITY OR TOWN Orofino
(If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location) 1223 Michigan

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CHARLES	A.	SHINE	Oct. 10 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Aug. 22, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 17	Timber	LaParte, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
August H. Shine	Colorado	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-03-7786	Emma R. Williams	Orofino, Ida.

18. CAUSE OF DEATH 4938

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	PNEUMONIA	12 HRS
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	SEVERE ARTERIOSCLEROSIS	10 YR

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* JAN, 19 66 *to* Oct 10, 19 67, *that I last saw the deceased alive on* Oct 10, 19 67 *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Orofino	10/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 14 1967	L-C Memorial Gardens	Lewiston Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1967	Jane M. Powell	[signature]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4470
Local Reg. No. 83
Reg. Dist. No. 210

BIRTH NO. -4

OCT 25 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 180 Clearwater 550
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural- Ahsahka
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Dworshak Dam Site 550

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 3139 - 7th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	TERRY	DeLINTON	BOOTH	12 October 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	14 February 1936	31				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Operating Engineer //	Construction	Glasgow, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Terry E. Booth	Minnesota	Bertha Garoutte	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Korean 7	539 30 0630	Diane Booth	Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 9123 Multiple Skull fracture + Brain hemorrhage - Seconds — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Heavy equipment overturning
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13	(COUNTY) 550	(STATE)
accident /	Dam Site 20			

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒	NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
10 - 12 - 67 22 m.			A front end loader overturned

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 8:20 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Larry D. Wunderlich 583 Coroner	Pierce Idaho	10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	26 Oct 1967	Spokane Memo. Cemetery	Spokane, Spokane Co., Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1967	Irene M. Powell	Lyle A. Stutzmann	476

FIRM NAME Malcom's Brower-Wann Memo. Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 25 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 14 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4471
Local Reg. No. 85
Reg. Dist. No. 210

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 30 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater 180 108
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
LENGTH OF STAY (in this place): 8 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 402 b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RUTH	MARIE	POWERS	October 22 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	June 21, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Washington	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Fitzgerald	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	—	518-03-0774	Records Christine Plourde	Orofino, Idaho

18. CAUSE OF DEATH 4200

MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Atherosclerotic heart disease — Several years

DUE TO (c) Infected decubitus ulcers — 2 weeks

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Intertrochomteric fracture of right femoral neck pinned. — 4 months

Chronic atherosclerotic brain syndrome with confusion — 10 months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept. 1, *19*67, *to* Oct. 22, *19* 67 *that I last saw the deceased alive on* Oct. 22, *19*67, *and that death occurred at* 4:40 pm., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
595 M.D.	M.D.	Box 672, Orofino, Idaho	Oct. 23, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct. 23, 1967	Cornell 's Ward's FH	Wallace Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 23, 1967	June M. Powell	Ivy C. A. Stratton	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4472
Local Reg. No. 86
Reg. Dist. No. 210

RECEIVED OCT 30 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 10 Clearwater 310
b. CITY OR TOWN Orofino
c. LENGTH OF STAY (in this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CV Hospital 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16 b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location) 412 Kalaspo Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	ALBERT	B.	PAPPENHAGEN	Oct.	24	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Feb. 2, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician-Surgeon	Medical	Perrysburg, New York	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles L. Pappenhagen	Denmark	Mary Abell	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	518-56-4741	Mary P. Joseph	Morris, Minn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebrovascular insufficiency — 2-3 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arthritis spine — 4 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July, 1963, *to* Oct, 1967, *that I last saw the deceased alive on* 10-24, 1967, *and that death occurred at* 2:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Orofino Idaho	10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 26 1967	Riverside	Orofino Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 27, 1967	June M. Powell	Lyle A. Stratmann	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 17 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4473
Local Reg. No. 87
Reg. Dist. No. 210

RECEIVED
OCT 30 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Clearwater
b. CITY OR TOWN: Greer
c. LENGTH OF STAY IN THIS PLACE: 14 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION: Arcadian Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN: Orofino
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	George		Lamp	Oct. 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	single	Mar. 18, 1881	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
woods worker	lumber	Finland	unknown

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unknown	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
unknown	518-01-4097	Lyle A. Stoltzmann	Orofino

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio sclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1966, *to* Oct, 1967, *that I last saw the deceased alive on* Oct 1, 1967, *and that death occurred at* 1:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Orofino Idaho	10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	10-25-67	Riverside	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 27, 1967	June M. Powell	Lyle A. Stoltzmann	476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4474
Local Reg. No. 10
Reg. Dist. No. 680

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 190 CUSTER. OCT 19 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Challis
c. LENGTH OF STAY (Hours, days)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 190 CUSTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Challis ~~Idaho~~
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) DAVE
b. (Middle)
c. (Last) ROBSON

4. DATE OF DEATH (Month) (Day) (Year) Oct 11, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH 21, Jan. 1892
9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months 8 Days 20 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Dubois, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Thomas A. Robson
BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME Lucretia Skeen
BIRTHPLACE Penna.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-2691
17. INFORMANT'S OWN SIGNATURE [signature] Robson
ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF ~~INJURY~~ DEATH (Month) (Day) (Year) (Hour) Oct 11, 1967 4:10 P.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE CUSTER COUNTY ~~CORONER~~ Glen W. Reed 583
23b. ADDRESS 4 Challis, Idaho
23c. DATE SIGNED 10-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem & Burial 3
24b. DATE 16 Oct. 1967
24c. NAME OF CEMETERY OR CREMATORY Rosehill Cemetery
24d. LOCATION (City, town, or county) (State) IDAHO falls, Idaho

DATE REC'D BY LOCAL REG. 10-17-67
REGISTRAR'S SIGNATURE Pauline J. Mulder
25. EMBALMER Leo A. Williams
LICENSE NO. E-319

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4475
Local Reg. No. 68
Reg. Dist. No. 380 391

BIRTH NO.

OCT 23 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 200 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Elmore Memorial Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Glenns Ferry
d. STREET ADDRESS (If rural, give location): Black Mesa Farms

3. NAME OF DECEASED (Type or Print): a. (First) MRS. b. (Middle) MARY c. (Last) MAXINE READ

4. DATE OF DEATH (Month) (Day) (Year): October 2, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 14, 1917

9. AGE (In years last birthday): 50
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook 01

10b. KIND OF BUSINESS OR INDUSTRY: Restuarant

11. BIRTHPLACE (State or foreign country): Council Grove, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Roy Dutton
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Mary Morris
BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 534-26-8967

17. INFORMANT'S OWN SIGNATURE: [signature]
ADDRESS: Glenns Ferry

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1707

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcimoma of Breast with metastases to lungs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Surgical removal of both breasts due to malignancy.

INTERVAL BETWEEN ONSET AND DEATH: months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation only, 19__, to __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith 583 (Degree or title): Coroner 4

23b. ADDRESS: Mountain Home, Idaho

23c. DATE SIGNED: 10/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/5/67

24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery

24d. LOCATION (City, town, or county) (State): Grandview, Idaho

DATE REC'D BY LOCAL REG.: Oct 17 1967

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Arthur Smith
LICENSE NO.: E-403
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 1 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4476
Local Reg. No. 69
Reg. Dist. No. 380 391

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 23 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Elmore 200 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Featherville
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7½ miles West of Featherville 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) Route 4, Sawtooth Bld

3. NAME OF DECEASED (Type or Print)
a. (First) MELVIN
b. (Middle) HARRISON
c. (Last) WILSON

4. DATE OF DEATH (Month) Oct (Day) 7 (Year) 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Dec. 10, 1929
9. AGE (In years last birthday) 37 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Instructor 12
10b. KIND OF BUSINESS OR INDUSTRY education
11. BIRTHPLACE (State or foreign country) Buhl, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Nelson W. Wilson — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Elsie Hranac — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) Korean 7
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Maxine Wilson — ADDRESS Buhl

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9/98

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inhalation of blood — INTERVAL BETWEEN ONSET AND DEATH hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Shattering of upper lobe right lung
DUE TO (c) Gunshot wound .300 Savage

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Mountain Area 09
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 200 **(STATE)** Rural - Featherville, Elmore, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10/7/67 3:00P m. 2
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Victim shot by another elk hunter.

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation only *, 19__, to __, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Arthur Smith 583 (Degree or title) Coroner 4
23b. ADDRESS Mountain Home, Idaho
23c. DATE SIGNED 10/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial removal 3
24b. DATE Oct 11, 1967
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. Oct 17 1967
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER H. Verl Humphreys
LICENSE NO. E-502

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4477
Local Reg. No. 70
Reg. Dist. No. 380 391

Certificate of Death

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200 410
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LIVING OR STAY (in this place) 10 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 370
b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bruneau
d. STREET ADDRESS (If rural, give location) Bruneau

3. NAME OF DECEASED (Type or Print)
a. (First) CHARLES
b. (Middle) ANDREW
c. (Last) HEWITT

4. DATE OF DEATH (Month) (Day) (Year) October 11, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Dec. 21, 1882
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY Farm & Stock
11. BIRTHPLACE (State or foreign country) Hiram, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Andrew Hewitt — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Clarisa Wilson — BIRTHPLACE Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Bernice Benham — ADDRESS Bruneau

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8121 Fracture cervical spine c transection spinal cord — INTERVAL BETWEEN ONSET AND DEATH hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 370 **(STATE)** Bruneau, Owyhee, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10/10/67 7:15 P m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Pedestrian victim bumped by pick-up backing from driveway

22. *I hereby certify that I attended the deceased from* Oct. 10, 1967, *to* Oct. 11, 1967, *that I last saw the deceased alive on* Oct. 11, 1967, *and that death occurred at* 8 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Malone W Jocksch 299 (Degree or title) — **23b. ADDRESS** Mountain Home Idaho — **23c. DATE SIGNED** Oct. 12 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 10/13/67
24c. NAME OF CEMETERY OR CREMATORY Bruneau Cemetery
24d. LOCATION (City, town, or county) (State) Bruneau, Idaho

DATE REC'D BY LOCAL REG. Oct 17 1967
REGISTRAR'S SIGNATURE P. Anderson
25. EMBALMER Arthur Smith
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4478
Local Reg. No. 71
Reg. Dist. No. 380 391

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 2½ mon.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 370
b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) GrandView
d. STREET ADDRESS (If rural, give location) Grand View

3. NAME OF DECEASED (Type or Print)
a. (First) MRS. b. (Middle) SYLVIA c. (Last) IRENE PILKINTON

4. DATE OF DEATH (Month) (Day) (Year) October 12, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 28, 1905
9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife OX
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Coquille, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jerry Peart — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Sadie — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 557-18-9455
17. INFORMANT'S OWN SIGNATURE R M Pilkinton — ADDRESS GV

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1538 Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 1966
19b. MAJOR FINDINGS OF OPERATION Carcinoma Colon
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1966, *to* Oct 12, 1967, *that I last saw the deceased alive on* Oct 11, 1967, *and that death occurred at* 3:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE Malone N Loebach M.D. Mountain Home Idaho (Degree or title) 28
23b. ADDRESS
23c. DATE SIGNED Oct 17, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/16/67
24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery
24d. LOCATION (City, town, or county) Mountain Home, Idaho (State)

DATE REC'D BY LOCAL REG. Oct 17 1967
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Arthur Smith
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 10 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4479
Local Reg. No. 21
Reg. Dist. No. 540

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 211 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 3 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 211
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 32 So. 4th East

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Mathew
c. (Last): Dalton

4. DATE OF DEATH (Month) (Day) (Year): Oct. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 1, 1891
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Retired)
10b. KIND OF BUSINESS OR INDUSTRY: 04
11. BIRTHPLACE (State or foreign country): Willard, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Alma Dalton — BIRTHPLACE: Willard, Utah
14. MOTHER'S MAIDEN NAME: Elizabeth Cook — BIRTHPLACE: Willard, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Hazel P. Dalton — ADDRESS: Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASVD + Diabetes Mellitus — 5 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Preston Franklin Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1967, to 10-10, 1967, that I last saw the deceased alive on 10-9, 1967, and that death occurred at 5:40 p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 119
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Grace Cemetery
24d. LOCATION (City, town, or county) (State): Grace, Idaho

DATE REC'D BY LOCAL REG.: 10-13-67
REGISTRAR'S SIGNATURE: Eppie W. Brower
25. EMBALMER: O. Sherwin Webb — LICENSE NO.: 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAY 8 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 5 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4480
Local Reg. No. 22
Reg. Dist. No. 340

BIRTH NO. RECEIVED STATE OF IDAHO 21 NOV 1 1967

1. PLACE OF DEATH
a. COUNTY: Franklin
b. CITY OR TOWN: Preston
c. LENGTH OF STAY (in this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): RFD Route # 3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): RFD Route # 3

3. NAME OF DECEASED (Type or Print): a. (First) Merlin; b. (Middle) Joseph; c. (Last) Larsen

4. DATE OF DEATH: (Month) (Day) (Year) Oct. 11, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Mar. 21, 1902

9. AGE (In years last birthday): 65
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Glendale, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Lars C. Larsen
BIRTHPLACE: Logan, Utah

14. MOTHER'S MAIDEN NAME: Elizabeth Ann Hebdon
BIRTHPLACE: Paris, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 03 0148

17. INFORMANT'S OWN SIGNATURE: Rosh P. Larsen
ADDRESS: Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): C V A — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis — 2 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Myocardosis — 1 yr

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-11, 19 67 *to* 10-11, 19 67 *that I last saw the deceased alive on* 10-11, 19 67, *and that death occurred at* 3 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: O. R. Cutler (Degree or title) MD
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Preston
24d. LOCATION (City, town, or county) (State): Preston Idaho

DATE REC'D BY LOCAL REG.: 10-11-67
REGISTRAR'S SIGNATURE: Eggie W. Brower

25. EMBALMER: O. Sherwin Webb
LICENSE NO.: 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4481
Local Reg. No. 93
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston 302
LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial Hospital 084

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 210
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dayton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Ellsworth b. (Middle) c. (Last) LaPray

4. DATE OF DEATH (Month) (Day) (Year) Oct. 20 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married 1

8. DATE OF BIRTH June 22, 1887

9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Rented farms

11. BIRTHPLACE (State or foreign country) Weston, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME David LaPray — BIRTHPLACE Scotland

14. MOTHER'S MAIDEN NAME Henrietta Hoffman — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 42 8109A

17. INFORMANT'S OWN SIGNATURE Adelia Profazio — ADDRESS Preston, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

1517

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 18 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5/9 *, 1967, to* 10/20 *, 1967, that I last saw the deceased alive on* 10/20 *, 1967, and that death occurred at* 7 p *m., from the causes and on the date stated above.*

23a. SIGNATURE Leo R. Hawkes (Degree or title) MD — **23b. ADDRESS** Preston Ida — **23c. DATE SIGNED** 10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** Oct. 24, 1967 — **24c. NAME OF CEMETERY OR CREMATORY** Weston — **24d. LOCATION** (City, town, or county) Weston, Idaho (State)

DATE REC'D BY LOCAL REG. 10-24-67 — **REGISTRAR'S SIGNATURE** Eggie W. Brower

25. EMBALMER Douglas S. Webb — **LICENSE NO.** 485

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4482
Local Reg. No. 2P
Reg. Dist. No. 540

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 210 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clifton
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clifton Canyon 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 011
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2207 No. 36th St.

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): H.
c. (Last): Clements

4. DATE OF DEATH (Month) (Day) (Year): Oct. 21, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 13, 1907
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor 08
10b. KIND OF BUSINESS OR INDUSTRY: State of Idaho
11. BIRTHPLACE (State or foreign country): Fairview, Oklahoma
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Joshua Clements — BIRTHPLACE: Unk.
14. MOTHER'S MAIDEN NAME: Jennie Rae — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 720 09 6684
17. INFORMANT'S OWN SIGNATURE: Anne Clements — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) A.S.V.D.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 12 m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Clair L. Cathy MD 119
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Clifton Cemetery
24d. LOCATION (City, town, or county) (State): Clifton, Idaho

DATE REC'D BY LOCAL REG.: 10-25-67
REGISTRAR'S SIGNATURE: Effie W. Brower
25. EMBALMER: O. Sherwin Webb — LICENSE NO. 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4483
Local Reg. No. 24
Reg. Dist. No. 54-0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 211 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 69 North 1st West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 21
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 69 North 1st West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Grover	Cleveland	Chatterton	Oct. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Aug. 13, 1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer (Retired) 04		Franklin, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Chatterton		Elizabeth Maria Stone	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Lenna D Chatterton	Preston Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary artery disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hpertensive — 2 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 6/16, 19 64, *to* 10/23, 19 67, *that I last saw the deceased alive on* 10/23, 1967, *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Leo R. Hawkes M.D. 214	Preston, Idaho	10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 25, 1967	Grace Cemetery	Grace, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-25-67	Eyre W. Brower	O. Sherwin Webb	316

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4484
Local Reg. No. 25
Reg. Dist. No. 540

RECEIVED
NOV 13 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 211 112
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 12 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 168 East 2nd South 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 211
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 168 East 2nd South

3. NAME OF DECEASED (Type or Print)
a. (First): Florence
b. (Middle): Isabell
c. (Last): Garner Rawlings

4. DATE OF DEATH (Month) (Day) (Year): Oct. 27 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 7, 1886
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Clifton, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: William Franklin Garner — BIRTHPLACE: Iowa Council Bluffs
14. MOTHER'S MAIDEN NAME: Mary Ann Barker — BIRTHPLACE: North Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-28-2736
17. INFORMANT'S OWN SIGNATURE: Aheron Rawlings — ADDRESS: Preston Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): CVA - Rt side paralysis — 1 yr.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1965, *to* Oct 27, 1967, *that I last saw the deceased alive on* Oct 26, 1967, *and that death occurred at* 2:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 119
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 10-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 31, 1967
24c. NAME OF CEMETERY OR CREMATORY: Preston
24d. LOCATION (City, town, or county) (State): Preston Idaho

DATE REC'D BY LOCAL REG.: 10-31-67
REGISTRAR'S SIGNATURE: Effie W. Brower
25. EMBALMER: O. Sherwin Webb — Sherwin Webb
LICENSE NO.: 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4485
Local Reg. No. 26
Reg. Dist. No. 540

BIRTH NO.

NOV 13 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Franklin 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 2 weeks 314
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin 211
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 221 South 1st East

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Joseph c. (Last) Fryer

4. DATE OF DEATH (Month) (Day) (Year): Oct. 30, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Oct. 7, 1888

9. AGE (In years last birthday): 79 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auditor 08

10b. KIND OF BUSINESS OR INDUSTRY: State Tax Commission

11. BIRTHPLACE (State or foreign country): Deweyville, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Lorenzo Fryer
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Mary Larsen
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 700 01 1864A

17. INFORMANT'S OWN SIGNATURE: Mrs. W. J. Fryer
ADDRESS: Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Ca of Colon - obstruction — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Arterio-sclerotic heart disease — 5 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 14, 1967, *to* Oct 30, 1967, *that I last saw the deceased alive on* Oct 30, 1967, *and that death occurred at* 1 57 *m., from the causes and on the date stated above.*

23a. SIGNATURE: O. R. Cutler (Degree or title): MD

23b. ADDRESS: Preston, Idaho

23c. DATE SIGNED: 11-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: November 1, 1967

24c. NAME OF CEMETERY OR CREMATORY: Logan Cemetery

24d. LOCATION (City, town, or county) (State): Logan, Utah

DATE REC'D BY LOCAL REG.: 11-1-67

REGISTRAR'S SIGNATURE: Esper W. Brower

25. EMBALMER: O. Sherwin Webb

LICENSE NO.: 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4486
Local Reg. No. 27
Reg. Dist. No. 640

RECEIVED
NOV 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Franklin 210
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston (rural)
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 91 South of Preston

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 211
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Newell		Hollingsworth	Oct 31, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	white	married 3	March 23, 1911	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Welder 21	metal work	Preston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Marvin David Hollingsworth		Annie Bosworth	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	720-09-3538	Hilda Hollingsworth	Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

8254

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Auto accident - head injury — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Chronic heart disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13	(COUNTY) 211	(STATE)
Accident	06	Preston	Franklin	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 11/9	Preston Idaho	11-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 4, 1967	Preston Cemetery	Preston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-4-67	Effie W. Brower	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: WEBB FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4487
Local Reg. No. 66
Reg. Dist. No. 651

Certificate of Death

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence of Mrs Hans Nielson 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 220
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): None Given

3. NAME OF DECEASED (Type or Print)
a. (First): LOUISE
b. (Middle): KATHERINE
c. (Last): THIELKE

4. DATE OF DEATH (Month) (Day) (Year): Sept. 22, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 7 Feb. 1878
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months 7, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: ———
11. BIRTHPLACE (State or foreign country): Elmira, New York
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Dietzman — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Katherine (Unknown) — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO.: 519-40-0662
17. INFORMANT'S OWN SIGNATURE: Family Records — ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 45 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertensive cardio-vascular disease 4 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 30 July, 1963, *to* 23 Sept., 1967, *that I last saw the deceased alive on* 19 Aug., 1967, *and that death occurred at* 3:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE 352 (Degree or title): W. A. Melcher, M.D.
23b. ADDRESS: Ashton, Idaho
23c. DATE SIGNED: 15 Oct. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 25 Sept. 67
24c. NAME OF CEMETERY OR CREMATORY: Emmett Cemetery
24d. LOCATION (City, town, or county) (State): Emmett, Gem Co., Idaho

DATE REC'D BY LOCAL REG.: 27 Oct 67
REGISTRAR'S SIGNATURE: M. D. Hansen
25. EMBALMER: Robert A. Bean — LICENSE NO. E-456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bean Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4488
Local Reg. No. 62
Reg. Dist. No. 651

BIRTH NO.

RECEIVED OCT 17 1967 Bureau of Vital

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Fremont 220 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (In this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 220
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Teton City
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) THOMAS b. (Middle) WALTER c. (Last) OWENS

4. DATE OF DEATH: (Month) Oct., (Day) 3, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 3 March 1898

9. AGE (In years last birthday): 69 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watermaster 08

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Paragonah, Utah

12. CITIZEN OF WHAT COUNTRY?: usa

13. FATHER'S NAME: Thomas Robert Owens — BIRTHPLACE: Panquitch, Utah

14. MOTHER'S MAIDEN NAME: Mary Louise Lamoreaux — BIRTHPLACE: Paragonah, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.: 518-10-0134

17. INFORMANT'S OWN SIGNATURE: Gary D. Owens — ADDRESS: Rexburg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerotic heart disease — 1 yr.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Uremia due to Spinal cord injury — 32 yrs.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 9-30 1967, *to* 10-3, 1967, *that I last saw the deceased alive on* 10-2- 1967 *and that death occurred at* 12:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: 298 (Degree or title)

23b. ADDRESS: Ashton - Idaho

23c. DATE SIGNED: 10-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 6 Oct 67

24c. NAME OF CEMETERY OR CREMATORY: Teton-Newdale Cemetery

24d. LOCATION (City, town, or county) (State): Sugar City, RFD, Idaho

DATE REC'D BY LOCAL REG.: 10 Oct 67

REGISTRAR'S SIGNATURE: M. L. Hansen

25. EMBALMER: M. L. Hansen — LICENSE NO.: E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendent. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4489
Local Reg. No. 64
Reg. Dist. No. 651

BIRTH NO.

OCT 19 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 220
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
d. STREET ADDRESS (If rural, give location): None Given

3. NAME OF DECEASED (Type or Print): a. (First) FERDINAND b. (Middle) de c. (Last) STWOLINSKI

4. DATE OF DEATH (Month) (Day) (Year): October 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	16 April 1885	82	9			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Surveyor - Engineer 08
10b. KIND OF BUSINESS OR INDUSTRY: County
11. BIRTHPLACE (State or foreign country): Fort Scott, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ferdinand deStwolinski — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Louisa Saal — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ------
16. SOCIAL SECURITY NO.: 518-09-4793
17. INFORMANT'S OWN SIGNATURE: Dorothy H. Nelson
ADDRESS: Pocatello Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of bladder — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1966, *to* Oct 5, 1967, *that I last saw the deceased alive on* Oct 5, 1967 *and that death occurred at* 7:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 29R (Degree or title)
23b. ADDRESS: Ashton, Idaho
23c. DATE SIGNED: 10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 9 Oct. 1967
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 17 Oct 67
REGISTRAR'S SIGNATURE: M. L. Hansen
25. EMBALMER: [signature]
LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Bean Funeral Home

NOV 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4490
Local Reg. No. 65
Reg. Dist. No. 630

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Fremont 22
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Fremont 22
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) 825 West Main

3. NAME OF DECEASED (Type or Print) a. (First) MARGARET b. (Middle) ELIZABETH c. (Last) VANDER LINDEN VANDER MEER

4. DATE OF DEATH (Month) (Day) (Year) Oct., 14, 1967

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH 30 Sept 1878
9. AGE (In years last birthday) 89
IF UNDER 1 YEAR Months 0 Days 14
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Pella, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Gerrit VanderLinden
BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Antoinette Robertus
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. No.
17. INFORMANT'S OWN SIGNATURE Leonard VanderMeer
ADDRESS Mesa, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis generalized due to — 10 years
DUE TO (c) Aging and Diabetes Mellitus — 2 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 1, 1965, *to* October 14 1967, *that I last saw the deceased alive on* October 14, 1967, *and that death occurred at* 12:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Robert R. Klamt, M.D.
23b. ADDRESS 325 East Main, St. Anthony, Idaho
23c. DATE SIGNED 10/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE 16 Oct 67
24c. NAME OF CEMETERY OR CREMATORY Lakeview Cemetery
24d. LOCATION (City, town, or county) (State) Lakeview, South Dakota

DATE REC'D BY LOCAL REG. 21 Oct 67
REGISTRAR'S SIGNATURE M. L. Hansen
25. EMBALMER M. L. Hansen
LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4491
Local Reg. No. 23
Reg. Dist. No. 340 341

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 231 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
LENGTH OF STAY (in this place) 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Emmett Valley Manor 302

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 231 b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 515 No. Commercial

3. NAME OF DECEASED (Type or Print) a. (First) Myrtle b. (Middle) L. c. (Last) Pryor
4. DATE OF DEATH (Month) (Day) (Year) Oct. 2, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2 widowed
8. DATE OF BIRTH Mar. 23, 1888
9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months 6 Days 19 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY 01 home
11. BIRTHPLACE (State or foreign country) Stanton, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William J. Pryor BIRTHPLACE Wisc.
14. MOTHER'S MAIDEN NAME Anna Zibler BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-40-0316
17. INFORMANT'S OWN SIGNATURE X Myrtle Colburn ADDRESS Rt 2 Box 250

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2002 Lymphosarcoma of Mediastinum

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized metastasis

DUE TO (c) from a malignant lymphoma

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 4 days approximately 5 years duration

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1960, *to* Oct 2, 1967, *that I last saw the deceased alive on* Oct 1, 1967, *and that death occurred at* 11:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Lucile P. Lawrence MD (Degree or title)
23b. ADDRESS Emmett Ida
23c. DATE SIGNED 10/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Oct. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY Emmett
24d. LOCATION (City, town, or county) Emmett, Idaho (State)

DATE REC'D BY LOCAL REG. Oct. 5 1967
REGISTRAR'S SIGNATURE Jean A Beatty
25. EMBALMER Glenn W Beatty
LICENSE NO. E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4492
Local Reg. No. 24
Reg. Dist. No. 340-341

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

OCT 9 1967

Bureau of Vital Statistics

1. PLACE OF DEATH 231

a. COUNTY: Gem 401

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett

c. LENGTH OF STAY (in this place): 1 hr.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hosp 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 231

b. COUNTY: Gem

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett

d. STREET ADDRESS (If rural, give location): 1039 Lincoln Ave.

3. NAME OF DECEASED (Type or Print)

a. (First): Lloyd

b. (Middle):

c. (Last): Hopkins

4. DATE OF DEATH (Month) (Day) (Year): Oct. 3, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Aug. 16, 1895

9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months 1, Days 17 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: farm

11. BIRTHPLACE (State or foreign country): Fort Scott, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Hopkins — BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Martha Stark — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI 3

16. SOCIAL SECURITY NO.: 518-10-2337

17. INFORMANT'S OWN SIGNATURE: X Ethel Hopkins — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Anterior myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: One hour

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1967, *to* Oct 3, 1967, *that I last saw the deceased alive on* Oct 3, 1967, *and that death occurred at* 5:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 429 (Degree or title): Ronald P. Rewhorn MD

23b. ADDRESS: Emmett Idaho

23c. DATE SIGNED: 10/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: October 7, 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Oct 4, 1967

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty

LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4493
Local Reg. No. 26
Reg. Dist. No. 340.341

RECEIVED
OCT 30 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 231 Gem 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 231
b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 613 So. Commercial

3. NAME OF DECEASED (Type or Print)
a. (First) May
b. (Middle) Anoette
c. (Last) Peterson

4. DATE OF DEATH (Month) (Day) (Year) Oct. 5, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Oct. 26, 1879
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Petersboro, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Kidman — BIRTHPLACE London, England
14. MOTHER'S MAIDEN NAME Elizabeth Hospool — BIRTHPLACE London England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 10 6352
17. INFORMANT'S OWN SIGNATURE X Florence L Whitsell — ADDRESS R R 2 Emmett Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH 16 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-23, 1954, *to* 10-5, 1967, *that I last saw the deceased alive on* 10-5, 1967, *and that death occurred at* 7:41 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Harmon E. Holverson MD 241 (Degree or title)
23b. ADDRESS Emmett, Idaho
23c. DATE SIGNED 10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Oct. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY Emmett
24d. LOCATION (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. Oct 16, 1967
REGISTRAR'S SIGNATURE Jean A Beatty
25. EMBALMER Glenn W Beatty
LICENSE NO. E392

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: The Beatty Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4494
Local Reg. No. 25
Reg. Dist. No. 340-341

BIRTH NO. RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Gem 23 OCT 9 1967 112
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 12 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 210 West 4th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 231 b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 210 West 4th

3. NAME OF DECEASED (Type or Print) a. (First) Louis b. (Middle) Heath c. (Last) Westbrook

4. DATE OF DEATH (Month) (Day) (Year) October 5, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH Nov. 28, 1897

9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months 11 Days 7 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming 04

10b. KIND OF BUSINESS OR INDUSTRY farm

11. BIRTHPLACE (State or foreign country) Peabody, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Roy Westbrook BIRTHPLACE Peabody, Kansas

14. MOTHER'S MAIDEN NAME Iva Heath BIRTHPLACE Crayon Co., Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 512-09-9949

17. INFORMANT'S OWN SIGNATURE X Vera L Westbrook ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2417

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchial asthma
DUE TO (c) & Pulmonary emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* approx 1940, *to* 5 Oct 1967, *that I last saw the deceased alive on* 5 Oct 1967, *and that death occurred at* 12 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE 184 (Degree or title) **23b. ADDRESS** Emmett, Ida. **23c. DATE SIGNED** 6 Oct 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial **24b. DATE** 10-7-67 **24c. NAME OF CEMETERY OR CREMATORY** Emmett **24d. LOCATION** (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. 10-9-67 **REGISTRAR'S SIGNATURE** Jean A Beatty

25. EMBALMER John W Beatty **LICENSE NO.** E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

SEP 26 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4495
Local Reg. No. 27
Reg. Dist. No. 340 341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 23 / Gem — OCT 30 1967 — 102
b. CITY OR TOWN Emmett — c. LENGTH OF STAY (in this place) 1 1/2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION Shady Lane Nursing Home 265

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 05 California — b. COUNTY 555 Santa Cruz
c. CITY OR TOWN Santa Cruz
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Laura		Reynolds	Oct. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	June 18, 1884	83	3	21		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Guy, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
G. F. Chappell	Trenton, Missouri	Sarah Stephenson	Trenton, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Mrs. Alice Cunningham	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4201 Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Oct, 1967, *that I last saw the deceased alive on* Sept 14, 1967, *and that death occurred at* 5:26 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B Jewell MD 260	1024 Locust, Emmett, Ida	10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal	Oct. 10, 1967	Santa Cruz	Santa Cruz, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 27, 1967	Jean A. Beatty	Allen W Beatty	E-392

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

JUN 20 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4496
Local Reg. No. 28
Reg. Dist. No. 340-341

RECEIVED OCT 30 1967 Bureau of Vital

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 230
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett rural
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3miles N.E. Hyway 52 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 080
b. COUNTY Boise
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Horseshoe Bend
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	Donald	Bridwell	Oct. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Nov. 30, 1906	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
laborer 17	lumber mill	Gallatin, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
M.C. Bridwell	Tenn.	Katie VanViver	Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WWII 4	519 05 4281	X Chas. F. Bridwell	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* never, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* app. 9Pm., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Glenn W Beatty 383	coroner Gem County	Emmett, Idaho	Oct. 24, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 25, 1967	Dry Creek	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 24, 1967	Jean A. Beatty	Glenn W Beatty	E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 31 1967
NOV 2 1967
DEC 1 1967
FEB 0 8 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4497
Local Reg. No. 29
Reg. Dist. No. 340-341

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 23 / Gem 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (In this place) 10months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Emmett Valley Nursing Home 086

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 23 / b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Route 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Mary	Etta	Bisom	Oct. 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 3	Sept. 3, 1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Springdale, Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William P. Walters	Springdale, Arkansas	Ada Taylor	Greenfield, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518 07 2693D	Frances M. Harris	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured Aortic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Gen. Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Sept, 1954, *to* Oct, 1967, *that I last saw the deceased alive on* Oct 23, 1967, *and that death occurred at* 4 00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B. Jewell M.D. 260 1		1024 E. Locust, Emmett, Idaho	10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 27, 1967	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 31, 1967	Mrs. C. Beatty	Glenn W. Beatty	E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 - 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4498
Local Reg. No. 30
Reg. Dist. No. 340-341

Certificate of Death

STATE OF IDAHO

RECEIVED Bureau of Vital Statistics NOV 6 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 23 Gem 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
LENGTH OF STAY (in this place) 23days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 23
b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) 314 So. Boise

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Don	Raymond	Leech	Oct. 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Mar. 28, 1883	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: education
11. BIRTHPLACE (State or foreign country): Custer Co., Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Corydon T. Leech — BIRTHPLACE: Ill.
14. MOTHER'S MAIDEN NAME: Anna D. Risley — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 536 22 4157A
17. INFORMANT'S OWN SIGNATURE: X Mabel Leech — ADDRESS

4201

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ess. Hypertension

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1954, *to* Oct, 1967, *that I last saw the deceased alive on* Oct 27, 1967, *and that death occurred at* 6 25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm B Jewell 260	M.D.	1024 E Locust, Emmett, Ida	11-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 31, 1967	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 6, 1967	Joan A Beatty	Glenn W Beatty	E392

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: The Beatty Chapel

DUTIES:

NOV 1 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 1 4 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 2 9 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 20 1972

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4499
Local Reg. No. 37
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED
NOV 13 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. [ICA 38-206 and 215.] Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 23 / 206
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 6 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Emmett Valley Manor 302

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 083 Boise
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Horseshoe Bend
d. STREET ADDRESS (If rural, give location): Box 74

3. NAME OF DECEASED (Type or Print): a. (First) Myrtle b. (Middle) Anna c. (Last) Bridwell

4. DATE OF DEATH: (Month) (Day) (Year): Oct. 28, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: June 2, 1891

9. AGE (In years last birthday): 76
IF UNDER 1 YEAR: Months 4 Days 26
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Gray's Harbor, Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Newell
BIRTHPLACE: Joplin, Missouri

14. MOTHER'S MAIDEN NAME: Julia Ann (unknown)
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 565-16-7385

17. INFORMANT'S OWN SIGNATURE: X Mrs. Harland M. Bridwell
ADDRESS: 12110 PALMCROFT HOUSTON, TEX.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Metestatic brain tumor — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Transitional cell carcinoma from nasopharynx — Unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-6, 19 67, *to* 10-28, 1967, *that I last saw the deceased alive on* 10-25, 19 67, *and that death occurred at* 5:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: T. E. Johnson M D (Degree or title)

23b. ADDRESS: Emmett, Idaho

23c. DATE SIGNED: 11-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Nov. 1, 1967

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek

24d. LOCATION (City, town, or county) (State): Ada Co., Idaho

DATE REC'D BY LOCAL REG.: Nov. 9 1967

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 0 8 1994

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4500
Local Reg. No. 32
Reg. Dist. No. 340-344

BIRTH NO.

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 23 Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 5 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 23
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Mounted Route

3. NAME OF DECEASED (Type or Print): a. (First) Freddie; b. (Middle) Lucille; c. (Last) Hyde

4. DATE OF DEATH (Month) (Day) (Year): Oct. 31, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: June 12, 1927

9. AGE (In years last birthday): 40 | IF UNDER 1 YEAR Months: 4 | Days: 19 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 00

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Emmett, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred Hyde — BIRTHPLACE: Robinsville, N. C.

14. MOTHER'S MAIDEN NAME: Alice Dillard — BIRTHPLACE: Sylvia, N. C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X Mozell M. Jones — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 223X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Neurofibromatosis & extention of tumors into the central nervous system — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1955, *to* Oct, 1967, *that I last saw the deceased alive on* Oct 31, 1967, *and that death occurred at* 9:55 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wm B. Jewell M.D. 260 (Degree or title) /

23b. ADDRESS: 1024 E. Locust, Emmett, Idaho

23c. DATE SIGNED: 11-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial /

24b. DATE: Nov. 3, 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Nov 6 1967

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty — LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4501
Local Reg. No. 3001
Reg. Dist. No. 420

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence (home) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 240
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hagerman
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Leora	Elaine	Pugmire	Oct. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Feb. 19, 1920	47				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Domestic	Hagerman, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fredrick L. Thompson	Gilman, Ida.	Mabel Green	Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	None	518-34-3009	X Marion Pugmire	Hagerman, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1750

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Cancer of Lt Ovary, — INTERVAL BETWEEN ONSET AND DEATH: 7 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Jan 1, 1944, *to* death, 19__, *that I last saw the deceased alive on* 10-5, 1967, *and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold G. Holsinger	MD	Wendell, Ida	10/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 11, 1967	Hagerman Cemetery	Hagerman Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 13, 1967	Kaleen S. Meyer	Robert S. Meyer	C-424

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 2 4 1992

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Klingler

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4502
Local Reg. No. 3003
Reg. Dist. No. 420

BIRTH NO.

OCT 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding 240 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding County Memorial 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 240 Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 538 Utah Street

3. NAME OF DECEASED (Type or Print)
a. (First): Ferdinand
b. (Middle): Louis
c. (Last): Pahl

4. DATE OF DEATH (Month) (Day) (Year): Oct. 9, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Sept. 22, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming 04
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Pine Island, Minn.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Christian F. Pahl-Brandenburg, Germany
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Amelia C. Michael-Brandenburg, Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 518-54-0931
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Carolyn Warner, Gooding, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia, Left lower lobe — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Bronchiectasis and Emphysema.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-3-67, *19*__, *to* 10-9-67, *19*__, *that I last saw the deceased alive on* 10-9-67, *19*__, *and that death occurred at* 11:05 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marvin J. Klingler 285
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: Oct. 12, 196

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-14-1967
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: Oct. 17, 1967
REGISTRAR'S SIGNATURE: Valerie S. Meyer
25. EMBALMER: Robert S. Meyer
LICENSE NO.: C-424

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Thompson Chapel-Gooding, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 22 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 29 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4503
Local Reg. No. 3002
Reg. Dist. No. 420

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: GOODING 240 146
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WENDELL
c. LENGTH OF STAY (in this place): 46 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MAGIC VALLEY MANOR 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 240
b. COUNTY: GOODING
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): WENDELL
d. STREET ADDRESS (If rural, give location): 247 3nd AV W.

3. NAME OF DECEASED (Type or Print)
a. (First): THOMAS
b. (Middle): H
c. (Last): HAWKES

4. DATE OF DEATH (Month) (Day) (Year): OCT. 12, 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRED 3
8. DATE OF BIRTH: DEC. 24, 1886
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER 04
10b. KIND OF BUSINESS OR INDUSTRY: AGG.
11. BIRTHPLACE (State or foreign country): SALT LAKE CITY UTAH.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: H.D. HAWKES — BIRTHPLACE: ENGLAND
14. MOTHER'S MAIDEN NAME: HANNAH WEST — BIRTHPLACE: ENGLAND
Elizabeth A. Hawkes Wendell Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-26-4320
17. INFORMANT'S OWN SIGNATURE: ELIZABETH A. HAWKES — ADDRESS: WENDELL IDAHO.

18. CAUSE OF DEATH 1530
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cancer of Cecum	1 yr
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Generalized Arteriosclerosis	10 yr.
DUE TO (c)	Coronary Atherosclerosis	5 yr
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Old age	

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1943, 19__, *to* death, 19__, *that I last saw the deceased alive on* 10/11, 1967, *and that death occurred at* 1 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Harold F. Holsinger MD 240 (Degree or title)
23b. ADDRESS: 1 Wendell, Idaho
23c. DATE SIGNED: 10/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 10/14/1967
24c. NAME OF CEMETERY OR CREMATORY: WENDELL
24d. LOCATION (City, town, or county) (State): GOODING, CO. IDAHO.

DATE REC'D BY LOCAL REG.: October 14, 1967
REGISTRAR'S SIGNATURE: Roberta Myers
25. EMBALMER: J. Farresh Weaver — LICENSE NO. E 353
FIRM NAME: Weaver Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:-

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4504
Local Reg. No. 3004
Reg. Dist. No. 420

Certificate of Death

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 24 Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY: 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho T.B. & Chest Disease Hosp. 04

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 370 Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Duck Valley Reservation
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Lewis
b. (Middle):
c. (Last): Dick

4. DATE OF DEATH (Month) (Day) (Year): 10-19-67

5. SEX: Male
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): single 1
8. DATE OF BIRTH: 11-14-42
9. AGE (In years last birthday): 24 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farm work 04
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Homedale, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hope Dick — BIRTHPLACE: Owyhee, Nev.
14. MOTHER'S MAIDEN NAME: Minnie Crow — BIRTHPLACE: Silver City, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-46-5796
17. INFORMANT'S OWN SIGNATURE: T.B. Hosp. records / K.A. Tyler M.D. — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic nephritis c uremia — INTERVAL BETWEEN ONSET AND DEATH: 6 mos +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Tuberculous disease — ?
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-28, 1967, *to* 10-19, 1967, *that I last saw the deceased alive on* 10-19, 1967, *and that death occurred at* 12:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE: K.A. Tyler M.D. 598 (Degree or title) 1
23b. ADDRESS: Idaho T.B. & Chest Dis Hosp Gooding, Idaho
23c. DATE SIGNED: 10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-23, 1967
24c. NAME OF CEMETERY OR CREMATORY: Owyhee Cemetery
24d. LOCATION (City, town, or county) (State): Owyhee Owyhee, Idaho.

DATE REC'D BY LOCAL REG.: 10-20-67
REGISTRAR'S SIGNATURE: Robert S. Meyer
25. FUNERAL DIRECTOR: Robert S. Meyer — ADDRESS: Thompson Chapel Gooding Idaho C-424

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

Mr Short -

Certificate of Death

STATE OF IDAHO

State File No. 4505
Local Reg. No. 3005
Reg. Dist. No. 420

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gooding 24B 000
b. CITY OR TOWN Gooding
LENGTH OF STAY (in this place) Aug. 1967
d. FULL NAME OF HOSPITAL OR INSTITUTION 701 3rd Avenue East 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 24B b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) 701 3rd Avenue East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Melva	Irene	Stagner	Oct. 21 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Sept. 19, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ida. State School & Laundry		Codell, Kansas.	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Overholser	Chattanooga, Tenn.	Belle Hoskins	Pleasanton, Iowa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-10-1169	X Velma Bissett	Gooding, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1992

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	~~Bad~~ Disseminated carcinoma	2 months
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 24 Aug, 1962, *to* 21 Oct, 1967, *that I last saw the deceased alive on* 21 Oct, 1967, *and that death occurred at* 6:07 p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Melvin Edmunds	MD	Gooding, Idaho	23 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-26-1967	Elmwood Cemetery	Gooding Gooding Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 26, 1967	Roberta Meyer	Roberta Meyer	E-424

FIRM NAME: Thompson Chapel Gooding, Idaho.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Klingler

Certificate of Death

RECEIVED

NOV 10 1967

Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4506
Local Reg. No. 3006
Reg. Dist. No. 426

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 240 Gooding 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding

DURATION OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gooding Co. Mem. Hosp. 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho b. COUNTY 240 Gooding

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerman

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Joseph	----	Haycock	Oct. 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 30, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Idaho Fish and Game Dept. 08		Nephi, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alfred Haycock	England	Sarah Jane Adams	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War I 3	518-07-2720	Della L. Haycock	Hagerman, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	1. Pneumonia	2 days.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease with failure	1 week
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Emphysema, marked.	years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct. 25, 1967, *to* Oct. 26, 1967, *that I last saw the deceased alive on* Oct. 26, 1967, *and that death occurred at* 9:40 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marvin W. Klingler M.D.	Gooding, Idaho	Nov. 1, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-30-1967	Hagerman Cemetery	Hagerman Gooding Co, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 4, 1967	Robert Meyer	Robert Meyer	E-424

FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 8 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Dr. Sacks

Certificate of Death

STATE OF IDAHO

State File No. 4507
Local Reg. No. 3007
Reg. Dist. No. 420

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 240 Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gooding Co. Mem. Hosp. 096

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 240
b. COUNTY Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
d. STREET ADDRESS (If rural, give location) 521 Nevada St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Charles	William	Flack	Oct. 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Cau.	Married 3	Sept. 7, 1885	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming and Plaster Work	04	Kassuth, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Abner Joseph Flack	Adams Co., Ill.	Sophia Ward	Troy, Pa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. #1	518-36-9115	X Winnie G. Flack	Gooding, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture iliac aneurysm — INTERVAL BETWEEN ONSET AND DEATH: 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 4 Jul, 1962, *to* 28 Oct, 1967, *that I last saw the deceased alive on* 28 Oct, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard Thomas MD	Gooding, Idaho	31 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-1-1967	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-31-1967	Roland D. Meyer	Eddie G. Leach	E-611

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Thompson Chapel - Gooding, Ida.

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4508
Local Reg. No. 3009
Reg. Dist. No. 420

Certificate of Death

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 240 GOODING 105
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WENDELL,
c. Vital Statistics STAY (in this place) 5 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MAGIC VALLEY MANOR 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 240 GOODING
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WENDELL
d. STREET ADDRESS (If rural, give location) 200 NO. IDAHO.

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle)
c. (Last) KNOPPHA

4. DATE OF DEATH (Month) (Day) (Year) OCT. 30, 1967

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2
8. DATE OF BIRTH APR. 21, 1861
9. AGE (In years last birthday) 106 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABOR 07
10b. KIND OF BUSINESS OR INDUSTRY MINING
11. BIRTHPLACE (State or foreign country) KOPECHAVA CO. POLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME MIKE KNOPPHA — BIRTHPLACE POLAND
14. MOTHER'S MAIDEN NAME MARY UNK. — BIRTHPLACE POLAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 517-01-7884
17. INFORMANT'S OWN SIGNATURE NO. RELATIVES — ADDRESS RECARDS MAGIC VALLEY MANOR

18. CAUSE OF DEATH 331X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b) Generalized Arteriosclerosis
~~DUE TO (c)~~ Prostatic Hypertrophy — 3 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Old age & Recent Pneumonia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-15, 1963, *to* death, 19__, *that I last saw the deceased alive on* 10/27, 1967, *and that death occurred at* 12 00 *m., from the causes and on the date stated above.*

23a. SIGNATURE Harold G. Holmes 240 (Degree or title) Mr
23b. ADDRESS Wendell, Ida
23c. DATE SIGNED 11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 11/1/1967
24c. NAME OF CEMETERY OR CREMATORY WENDELL
24d. LOCATION (City, town, or county) (State) GOODING CO. IDAHO.

DATE REC'D BY LOCAL REG. Nov. 2, 1967
REGISTRAR'S SIGNATURE J. Robert Meyer
25. EMBALMER J. Farrish Weaver — LICENSE NO. E 353
FIRM NAME: Weaver mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4509
Local Reg. No. 3008
Reg. Dist. No. 420

BIRTH NO.

NOV 10 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 24 Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gooding
c. LENGTH OF STAY IN THIS PLACE 5 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho Tuberculosis & Chest Dis. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 6515 Fairview

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) Charles c. (Last) Stang

4. DATE OF DEATH (Month) October (Day) 31 (Year) 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH March 22, 1890

9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Salesman 24 Textile

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Glencoe, Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Stang — BIRTHPLACE Brooklyn, N.Y.

14. MOTHER'S MAIDEN NAME Mary Specth — BIRTHPLACE Oshkosh, Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 531-16-6403A

17. INFORMANT'S OWN SIGNATURE Hospital Records, I.W. Morris M.D. — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary tuberculosis, with cavities — INTERVAL BETWEEN ONSET AND DEATH: 11 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death* abdominal aortic aneurysm; Gastrectomy, old, 1948 for carcinoma

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1967, *to* Oct. 31, 1967, *that I last saw the deceased alive on* Oct. 31, 1967, *and that death occurred at* 5:40 P m., *from the causes and on the date stated above.*

23a. SIGNATURE I.W. Morris 598 (Degree or title) M.D. — **23b. ADDRESS** Tyler Hall, Gooding, Ida. — **23c. DATE SIGNED** 10-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation — **24b. DATE** 11-6-67 — **24c. NAME OF CEMETERY OR CREMATORY** Mtn. View Cemetery — **24d. LOCATION** (City, town, or county) Boise Ada (State) Idaho

DATE REC'D BY LOCAL REGR. Nov 2, 1967 — REGISTRAR'S SIGNATURE Frank Meyer

25. FUNERAL DIRECTOR Forrest Meyer Thompson — ADDRESS Gooding Idaho

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

JAN 19 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

*ADDITIONAL REMARKS by Physician.....

Dr. Klingler

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4510
Local Reg. No. 3010
Reg. Dist. No. 420

BIRTH NO.

NOV 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gooding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hosp. 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
d. STREET ADDRESS (If rural, give location): 1214 California St.

3. NAME OF DECEASED (Type or Print)
a. (First): Maynard
b. (Middle): Vincent
c. (Last): Hill

4. DATE OF DEATH (Month) (Day) (Year): Oct. 31, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 24, 1905
9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager Of Credit
10b. KIND OF BUSINESS OR INDUSTRY: Company 26
11. BIRTHPLACE (State or foreign country): Sterling, Colorado
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William E. Hill
BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Dolly Patterson
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-24-2602
17. INFORMANT'S OWN SIGNATURE: William M. Hill
ADDRESS: Gooding, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH: 30 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 30, 1967, *to* Oct 31, 1967 *that I last saw the deceased alive on* Oct 31, 1967, *and that death occurred at* 5:50 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Marvin V. Klingler 285 (Degree or title)
23b. ADDRESS: Gooding, Idaho
23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-3-1967
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: Nov. 7, 1967
REGISTRAR'S SIGNATURE: Eileen S. Meyer
25. EMBALMER: Robert S. Meyer
LICENSE NO.: E-424

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Thompson Chapel-Gooding, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4511
Local Reg. No. 182
Reg. Dist. No. 244

STATE OF IDAHO

BIRTH NO.

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN: Stites
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hiway 13 - 5 Miles South 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Bruce b. (Middle) Bennett c. (Last) Petrick

4. DATE OF DEATH: (Month) Oct. (Day) 3 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: January 12, 1945

9. AGE (In years last birthday): 22
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Mechanic 05

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army

11. BIRTHPLACE (State or foreign country): Grangeville Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wilfred B. Petrick
BIRTHPLACE: Waitsburg Wn.

14. MOTHER'S MAIDEN NAME: Elizabeth Anne Collins
BIRTHPLACE: Stites Idaho.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Apr. 1963 - April 1965

16. SOCIAL SECURITY NO.: 519-50-3566

17. INFORMANT'S OWN SIGNATURE: Wilfred B. Petrick
ADDRESS: Kooskia Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ~~ACCIDENT~~ SUICIDE HOMICIDE (Specify): 5. Fork

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Clearwater R. 18

21c. (CITY, TOWN, OR TOWNSHIP): Ida. (COUNTY): 250 (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 30 Oct 67 2 p m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Car accident to R. Boat pt. bl. from state

22. *I hereby certify that I attended the deceased from* Never, 19__ *to* Day pt. bl. from state, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* 2 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton Hill Witness MD

23b. ADDRESS: Grangeville Ida.

23c. DATE SIGNED: 30 Oct. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 7 1967

24c. NAME OF CEMETERY OR CREMATORY: Pine Grove

24d. LOCATION (City, town, or county): Kooskia (State): Idaho

DATE REC'D BY LOCAL REG.: Oct. 14 1967

REGISTRAR'S SIGNATURE: Claude Mercy

25. EMBALMER: Robert G. Hansen
LICENSE NO.: E433

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4512
Local Reg. No. 59
Reg. Dist. No. 240

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 404
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elk City Rural
LENGTH OF STAY (in this place): hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): American River Area 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 05 California
b. COUNTY: 533 Siskiyo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mt. Shasta
d. STREET ADDRESS (If rural, give location): South Ream Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle): THOMAS
c. (Last): SMITH

4. DATE OF DEATH (Month) (Day) (Year): October 7, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: February 22, 1937
9. AGE (In years last birthday): 30 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY: Sand & Gravel
11. BIRTHPLACE (State or foreign country): Sabinal, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John C. Smith — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Florane, Pruitt, — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1960-1961
16. SOCIAL SECURITY NO.: 523 48 2762
17. INFORMANT'S OWN SIGNATURE: John C. Smith — ADDRESS: Mt Shasta, Calif

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9198

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gunshot Wounds to chest — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ē Fatal Damage to both
DUE TO (c): lungs, spine & aorta

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: none found

19a. DATE OF OPERATION: 8 Oct, 67
19b. MAJOR FINDINGS OF OPERATION: as above stated
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1 near
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Elk City, Idaho 12
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 250 **(STATE)**: Idaho, Ida.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct, 7, 67, 8:35 A.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: Gunshot

22. *I hereby certify that I attended the deceased from* never saw, victim before, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 8:35 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton H. Wiltse 621 M.D. 1
23b. ADDRESS: Grangeville, Ida.
23c. DATE SIGNED: 9 Oct, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Transportation
24b. DATE: 10/9/67
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county) (State): Mt Shasta, California

DATE REC'D BY LOCAL REG.: Oct. 13, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R Hansen — Robert R Hansen
LICENSE NO.: E433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 17 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 12 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4513
Local Reg. No. 60
Reg. Dist. No. 240

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville 201
d. STREET ADDRESS (If rural, give location): 228 South Florence

3. NAME OF DECEASED (Type or Print): a. (First) WILL b. (Middle) EVERT c. (Last) JOHNSTON

4. DATE OF DEATH (Month) (Day) (Year): October 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug 25, 1886

9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Burlington Junction, Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Milton J. Johnston

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Della Castle Manning, Rochester, Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 36 4824

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Harold W Johnston

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arrythmia & — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (c) Congestive Heart Fail. — INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 Sept, 1967, *to* 7 Oct, 1967, *that I last saw the deceased alive on* 7 Oct, 1967, *and that death occurred at* 12:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): Milton 62 Wilson MD — **23b. ADDRESS**: Grangeville Idaho — **23c. DATE SIGNED**: 12 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Oct. 12, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Prairieview Cemetery — **24d. LOCATION** (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Oct. 14, 1967 — REGISTRAR'S SIGNATURE: Irma Cone

25. EMBALMER: Robert P Hansen — LICENSE NO.: E 433.

FIRM NAME: Robertson-Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 20 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4514
Local Reg. No. 62
Reg. Dist. No. 240

BIRTH NO.

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

101

1. PLACE OF DEATH
a. COUNTY: 250 Idaho
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 9 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Hill Nursing Home 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Harpster
d. STREET ADDRESS (If rural, give location): Harpster, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): BESSIE
b. (Middle): MAUDE
c. (Last): HOPPER

4. DATE OF DEATH (Month) (Day) (Year): October 11, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: December 25, 1893

9. AGE (In years last birthday): 73
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Shawnee, Oklahoma

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Johns
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Anna Mise
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 28 6472

17. INFORMANT'S OWN SIGNATURE: Walter Roberts
ADDRESS: Harpster, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Lung Abscess — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Aspiration of food — 3 Days
DUE TO (c): Stroke c. Arteriosclerosis — years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chronic abdominal pain.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* May, 1967 *to* Oct 11, 1967, *that I last saw the deceased alive on* Oct 11, 1967, *and that death occurred at* 6:45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William H. Greenwood MD
23b. ADDRESS: Grangeville, Idaho 83530
23c. DATE SIGNED: 10-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE:
24c. NAME OF CEMETERY OR CREMATORY: Keithly Creek
24d. LOCATION (City, town, or county) (State): Midvale, Idaho

DATE REC'D BY LOCAL REG.: Oct. 19 1967
REGISTRAR'S SIGNATURE: Irma Cozet
25. EMBALMER: Robert R Hansen Robert R Hansen
LICENSE NO.: E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4515
Local Reg. No. 61
Reg. Dist. No. 240

67-10034 RECEIVED
BIRTH NO.

OCT 23 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
Statistical No. OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 249
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kamiah
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	Stacy	Leon	Kornoely

4. DATE OF DEATH (Month) (Day) (Year): Oct. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white		Oct. 13 1967	0	0	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
02		Grangeville Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lester Kornoely	Kamiah, Idaho	Verna Payton	Seattle, Wn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Lester W Kornoely	Kamiah, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7235

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyaline membrane Disease — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Prematurity (Born 6 wks premature) —

DUE TO (c) twin often delivered early. —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 13, 1967, *to* Oct 15, 1967, *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at* 4:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William H Greenwood	MD	Grangeville Idaho	10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 17 1967	Pine Grove	Kooskia Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 19 1967	Irma Cone	Robert R Hansen	E433

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 36-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 2 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4516
Local Reg. No. 64
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Craigmont
d. STREET ADDRESS (If rural, give location): 13 miles northeast

3. NAME OF DECEASED (Type or Print): a. (First) EUGENE b. (Middle) WILLIAM c. (Last) LANGDON

4. DATE OF DEATH: (Month) October (Day) 15, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: March 25, 1883

9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: farming

11. BIRTHPLACE (State or foreign country): Carrol County, Missouri

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Albert Langden — BIRTHPLACE: Michigan

14. MOTHER'S MAIDEN NAME: Annette Terry — BIRTHPLACE: New York State

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-40-3790

17. INFORMANT'S OWN SIGNATURE: x Edna B. Stalnaker — ADDRESS: Orofino, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3318

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 16 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral Vascular accident — 18 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Arteriosclerotic Heart Disease with Congestive Heart Failure — 2 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 1, 1965 *to* Oct 15, 1967, *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at* 5:30 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE: 373 (Degree or title): MD — **23b. ADDRESS**: Grangeville, Id. — **23c. DATE SIGNED**: 10/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial — **24b. DATE**: October 17, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Craigmont Cemetery — **24d. LOCATION** (City, town, or county) (State): Craigmont Idaho

DATE REC'D BY LOCAL REG.: Oct 25, 1967 — **REGISTRAR'S SIGNATURE**: Irma Cone

25. EMBALMER: Robert R Hansen — **LICENSE NO.**: 433

FIRM NAME: Robertson-Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4517
Local Reg. No. 68
Reg. Dist. No. 240

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 25
b. CITY OR TOWN: Grangeville
c. LENGTH OF STAY IN (this place): 24 hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION: Grangeville General Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 38
b. COUNTY: Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
d. STREET ADDRESS (If rural, give location): Kamiah, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) ANDREW b. (Middle) Ika c. (Last) DOTY

4. DATE OF DEATH: (Month) Oct (Day) 16, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug 23, 1881

9. AGE (In years last birthday): 86 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Pullmann, Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Levi Doty — BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Ida Glaspey — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-44-3443

17. INFORMANT'S OWN SIGNATURE: Ika Doty — ADDRESS: Kamiah, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Small bowel obstruction — INTERVAL BETWEEN ONSET AND DEATH: 30 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) volvulus of small intestine — 30 hrs

DUE TO (c) adhesions — unkn.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* severe arteriosclerotic Heart Disease with intractable Congestive Heart Failure

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Per 1a and b

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* September 1966, *to* October 16, 1967, *that I last saw the deceased alive on* Oct. 16, 1967, *and that death occurred at* 11:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Morrison M.D. 373 — **23b. ADDRESS**: Grangeville, Id. — **23c. DATE SIGNED**: 11/

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Oct 20, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Kamiah — **24d. LOCATION** (City, town, or county) (State): Kamiah, Idaho

DATE REC'D BY LOCAL REG.: Nov. 15, 1967 — REGISTRAR'S SIGNATURE: Irma Cone

25. EMBALMER: Robert K Hansen Robert K Hansen — LICENSE NO.: E 433

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4518
Local Reg. No. 65
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 NOV 2 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rural - Slate Creek 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 287 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur D' Alene
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) THOMAS; b. (Middle) ROBERT; c. (Last) ROE

4. DATE OF DEATH: (Month) October (Day) 18 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: April 30, 1934

9. AGE (In years last birthday): 33 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): saw mill worker 17

10b. KIND OF BUSINESS OR INDUSTRY: cut saw mill

11. BIRTHPLACE (State or foreign country): Rupert, Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Percy I. Roe — BIRTHPLACE: Rupert, Idaho

14. MOTHER'S MAIDEN NAME: Ethel May Thacker — BIRTHPLACE: Medford, Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Korean Conflict

16. SOCIAL SECURITY NO.: 7518 36 1787

17. INFORMANT'S OWN SIGNATURE: Percy Roe — ADDRESS: Lewiston Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound to Head — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) massive; instant
DUE TO (c) death

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none known of

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 12 Box Canyon, Salmon R., between Whitebird & Riggins

21c. (CITY, TOWN, OR TOWNSHIP): Whitebird — (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 19 Oct. 67 6 A. m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑

21f. HOW DID INJURY OCCUR?: above stated

22. *I hereby certify that I attended the deceased from* never saw to before, 19 death, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 6 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Milton H. Wittee, M.D.

23b. ADDRESS: Grangeville, Ida.

23c. DATE SIGNED: 30 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 19, 1967

24c. NAME OF CEMETERY OR CREMATORY:

24d. LOCATION (City, town, or county) (State): Lewiston-Nezperce Idaho

DATE REC'D BY LOCAL REG.: Oct 27 1967

REGISTRAR'S SIGNATURE: Irma Cone

25. EMBALMER: Robert R Hansen — LICENSE NO.: E433

FIRM NAME: Robertson-Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 3 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4519
Local Reg. No. 783
Reg. Dist. No. 244

BIRTH NO.

RECEIVED NOV 6 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Idaho 23J 142
b. CITY OR TOWN Kooskia
c. LENGTH OF STAY IN (this place) 42 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION At home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Idaho 23J
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kooskia
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Earl b. (Middle) Reuben c. (Last) Whitney

4. DATE OF DEATH (Month) Oct. (Day) 18 (Year) 1967

5. SEX Male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH Jan. 17, 1886

9. AGE (In years last birthday) 81 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Road Grader Operator

10b. KIND OF BUSINESS OR INDUSTRY State Hiway Dept

11. BIRTHPLACE (State or foreign country) Napleton, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Reuben Henry Whitney BIRTHPLACE Unk.

14. MOTHER'S MAIDEN NAME Esther Annetta Holliday BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-20-5919

17. INFORMANT'S OWN SIGNATURE Mrs. L. W. Barlow ADDRESS Kooskia Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left ventricular failure — INTERVAL BETWEEN ONSET AND DEATH Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) arteriosclerotic heart disease — several years.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* about May, 1965 *to* 18 Oct, 1967, *that I last saw the deceased alive on* 13 Oct, 1967, *and that death occurred at* 6 A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Donald Altman M.D. 487

23b. ADDRESS Orangeville, Idaho

23c. DATE SIGNED 26 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 21, 1967

24c. NAME OF CEMETERY OR CREMATORY Lewis Clark Mem. Gardens

24d. LOCATION (City, town, or county) Lewiston (State) Idaho

DATE REC'D BY LOCAL REG. 11/3/67

REGISTRAR'S SIGNATURE Maurice Trenary

25. EMBALMER Robert P. Hansen LICENSE NO. E423

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4520
Local Reg. No. 66
Reg. Dist. No. 240

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 250 Idaho 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
c. LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Grangeville General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 250
b. COUNTY Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) 502 South Idaho Street

3. NAME OF DECEASED (Type or Print)
a. (First) PRITCHARD
b. (Middle) ALEXANDER
c. (Last) CROWELL

4. DATE OF DEATH (Month) (Day) (Year) October 28, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH November 1, 1910
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Medical Technologist 21
10b. KIND OF BUSINESS OR INDUSTRY Medical
11. BIRTHPLACE (State or foreign country) Asheville, North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Earnest B. Crowell — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Georgia Sorrel — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 536 03 1343
17. INFORMANT'S OWN SIGNATURE + Martha F. Crowell — ADDRESS Grangeville, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest 2° to

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Myocardial Infarction
DUE TO (c) Severe Coronary Insufficiency & previous

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Infarctions & Angina.
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* attended per my partner, Dr. Soltman, *19 to 19, that I last saw the deceased alive on* 28 Oct, 1967, *and that death occurred at* 3:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Milton G. Wiltsey, M.D. 621 (Degree or title)
23b. ADDRESS Grangeville, Idaho
23c. DATE SIGNED 31 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/31/67
24c. NAME OF CEMETERY OR CREMATORY Prairieview
24d. LOCATION (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. Nov. 4, 1967
REGISTRAR'S SIGNATURE Irma Cone
25. EMBALMER Robert R. Hansen Robert R. Hansen
LICENSE NO. E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robertson-Hansen funeral home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4521
Local Reg. No. 784
Reg. Dist. No. 244

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Stites
c. LENGTH OF STAY (in this place): 2 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At home of Estella Blewett 402

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 27 Montana
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Missoula
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Charles b. (Middle) Francis c. (Last) Pirley

4. DATE OF DEATH: (Month) October (Day) 28 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Feb. 23, 1904

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Supervisor

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Forest Service

11. BIRTHPLACE (State or foreign country): Lewiston, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Orin F. Pixley
BIRTHPLACE: Unk

14. MOTHER'S MAIDEN NAME: Elizabeth Deschamps
BIRTHPLACE: Ellendale N.D.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-03-9325

17. INFORMANT'S OWN SIGNATURE: Rosalie Pixley
ADDRESS: Kamiah, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Many years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 15, 1965, *to* 10-2, 1965, *that I last saw the deceased alive on* 10-2, 1965, *and that death occurred at* 4:00 p.m., *from the causes and on the date stated above.* 10-28-67

23a. SIGNATURE: [signature] 652 (Degree or title)
23b. ADDRESS: KAMIAH IDAHO
23c. DATE SIGNED: 10-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-burial
24b. DATE: Oct 31 1967
24c. NAME OF CEMETERY OR CREMATORY: St. Mary's
24d. LOCATION (City, town, or county) (State): Missoula Montana

DATE REC'D BY LOCAL REG.: 11/3/67
REGISTRAR'S SIGNATURE: Claude Trenary

25. EMBALMER: Robert R Hansen
LICENSE NO.: E433
FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4522
Local Reg. No. 12
Reg. Dist. No. 640

RECEIVED NOV 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260 102
b. CITY OR TOWN: Rigby
LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Carson Rest Home 097

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 101
b. COUNTY: Bonneville
c. CITY OR TOWN: Idaho Falls
d. STREET ADDRESS (If rural, give location): 303 Melbourne Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Lillie		Lowe	September 26 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	January 22, 1878	89		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Mt. Pleasant, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Isacc Allred	USA	Jerushia	USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	Unknown	L. Lowe	Idaho Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	none performed	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-3-, 1965, *to* Sept. 26, 1967, *that I last saw the deceased alive on* 25 Sept., 1967, *and that death occurred at* 5:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Asael Hall,	522 M.D.	Rigby, Idaho	9-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/29/67	Rose Hill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9/28/67	Mrs A B Rockwell	Ralph M. Wood Ralph M Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 10 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 25 2015

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4523
Local Reg. No. 13
Reg. Dist. No. 6-40

RECEIVED NOV 2 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Garfield (rural)
c. LENGTH OF STAY (in this place): 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rte. #1 Rigby 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 260
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Garfield (rural)
d. STREET ADDRESS (If rural, give location): Rte. #1 Rigby

3. NAME OF DECEASED (Type or Print): a. (First) HENRY b. (Middle) FRANKLIN c. (Last) HULSE

4. DATE OF DEATH: (Month) Octobef (Day) 11, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 12, 1874

9. AGE (In years last birthday): 93
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farm

11. BIRTHPLACE (State or foreign country): Millville, Utah.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Edward Hulse
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Mary Jane Weaver
BIRTHPLACE: Provo, Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-09-2177

17. INFORMANT'S OWN SIGNATURE: Naomi H. Butikofer
ADDRESS: Rigby, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/2/54 *to* 10/11/67, *that I last saw the deceased alive on* 10/3/67, *and that death occurred at* 7:00 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Alden Hall, 521
(Degree or title): M.D.

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED: 10/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 14, 1967

24c. NAME OF CEMETERY OR CREMATORY: Pioneer

24d. LOCATION (City, town, or county) (State): Rigby, Jefferson, Idaho

DATE REC'D BY LOCAL REG.: 10/16/67

REGISTRAR'S SIGNATURE: Mrs. A B Eckersell

25. EMBALMER: Bruce A. Eckersell
LICENSE NO.: Bruce A. Eckersell E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 23 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4524
Local Reg. No. 144
Reg. Dist. No. 640

RECEIVED
NOV 2 1 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: JEFFERSON 260 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Monteview
c. LENGTH OF STAY IN this place: years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): X 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Monteview
d. STREET ADDRESS (If rural, give location): X

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALBERT	FRANK	VIOLETTE	Oct. 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Sept. 24, 1912	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Shop owner 22	repair	Anaconda, Montana.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Violette	Quebec, Can.	Clara Harris	Anaconda, Mont.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	516-01-8382	Mrs Al Violette	Monteview, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 19 67, *to* 10-30, 19 67, *that I last saw the deceased alive on* 10-1, 19 67, *and that death occurred at* 7:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Leslie L. Peterson 423 (Degree or title) M.D.	Rexburg, Idaho.	Nov. 1, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 2, 1967	Little Butte	Annis Jefferson Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 1 1967	Mrs A B Eckersell	Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4526
Local Reg. No. 1036
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital 089

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 429 2nd. Ave. East

3. NAME OF DECEASED (Type or Print)
a. (First) ALFRED
b. (Middle)
c. (Last) KENYON

4. DATE OF DEATH (Month) (Day) (Year) Oct. 1, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 18, 1893
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logger 17
10b. KIND OF BUSINESS OR INDUSTRY Lumber
11. BIRTHPLACE (State or foreign country) Round Mountain, Calif.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Rufus Kenyon — BIRTHPLACE California
14. MOTHER'S MAIDEN NAME Cordelia Thomas — BIRTHPLACE California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W. W. I 3
16. SOCIAL SECURITY NO. 544 12 6762
17. INFORMANT'S OWN SIGNATURE Nancy W Kenyon — ADDRESS Jerome, Ida.

154X

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rectal carcinoma — INTERVAL BETWEEN ONSET AND DEATH approx 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Obliterative arteriosclerosis — Vmos

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1964, *to* 1 Oct, 1967, *that I last saw the deceased alive on* 1 Oct, 1967, *and that death occurred at* 5:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) L. M. Leher, Cor D 385 1
23b. ADDRESS Jerome
23c. DATE SIGNED 3 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. Oct. 5, 1967
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 11 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 7 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

State File No. 4527
Local Reg. No. 1037
Reg. Dist. No. 440

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Jerome 270 OCT 9 1967 000
b. CITY OR TOWN Jerome
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Rt. 1 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270 b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) 83338
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CALVIN	RAY	NIX	Oct. 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Oct. 9, 1911	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Berryville, Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
O. A. Nix	Arkansas	Mamie Kipper	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 22 7051	X Mrs Calvin R Nix	Rt. 1, Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Probable Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 0 // Died while alone
DUE TO (c) at work in a field on his farm

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
0		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1950, 19___, *to* 1964, 19___, *that I last saw the deceased alive on* 9/24/67, 19___, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Coryle Orail MD	Jerome, Idaho	10/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 6, 1967	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 6 1967	Louella M. Scherer	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Hove Funeral Chapel

DUTIES:

OCT 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4528
Local Reg. No. 1038
Reg. Dist. No. 440

BIRTH NO.

RECEIVED OCT 20 1967 Bureau of Vital Statistics

Inform, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Hosp. 090

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 270
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print): a. (First) Maxie b. (Middle) H. c. (Last) Thompson

4. DATE OF DEATH (Month) (Day) (Year): October 14, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Oct. 10, 1916

9. AGE (In years last birthday): 51 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookeeper 19

10b. KIND OF BUSINESS OR INDUSTRY: Dept. Store

11. BIRTHPLACE (State or foreign country): Malad City, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lorenzo Harrison — BIRTHPLACE: Malad, Idaho

14. MOTHER'S MAIDEN NAME: Edith Mock — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 528-28-3539

17. INFORMANT'S OWN SIGNATURE: Harold Thompson ADDRESS: Jerome, Idaho 83338

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Breast — INTERVAL BETWEEN ONSET AND DEATH: 9 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 4/5/58

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of breast & axillary metastases

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 16, 19 54, *to* Oct 14, 1967, *that I last saw the deceased alive on* Oct 13, 1967, *and that death occurred at* 2:15a m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. E. Moar 476 (Degree or title): M.D.

23b. ADDRESS: Jerome Idaho 83338

23c. DATE SIGNED: 10/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 16, 1967

24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery

24d. LOCATION (City, town, or county) (State): Jerome, Idaho 83338

DATE REC'D BY LOCAL REG.: October 17 1967

REGISTRAR'S SIGNATURE: Maxine Gene Overfield

25. EMBALMER: Ronald J. Hamilton — LICENSE NO.: E-470

Federal Security Agency
United States Public Health Service

Form DH-63021 Letter Reg. — FIRM NAME: Hove Funeral Chapel

DUTIES:

OCT 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended October 31, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4529
Local Reg. No. 1040
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place): days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 330
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Frederic; b. (Middle) Richard; c. (Last) Mabbutt

4. DATE OF DEATH: (Month) (Day) (Year): October 15, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug 6, 1915

9. AGE (In years last birthday): 52 | IF UNDER 1 YEAR Months: 2 | Days: 9 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Materials Technician 68

10b. KIND OF BUSINESS OR INDUSTRY: Highway Dept.

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: B. Ambrose Mabbutt
BIRTHPLACE: Linvill, Iowa

14. MOTHER'S MAIDEN NAME: Evelyn Meyers
BIRTHPLACE: Hailey, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II 4

16. SOCIAL SECURITY NO.: 712-09-7580

17. INFORMANT'S OWN SIGNATURE: Helen A. Mabbutt
ADDRESS: Shoshone, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1637

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Metastatic Ca of R lung — INTERVAL BETWEEN ONSET AND DEATH: 8 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* January, 1967, *to* Oct 15, 1967, *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at* 3:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. G. Neher, M.D. 385
23b. ADDRESS: Box 68, Shoshone, Idaho
23c. DATE SIGNED: 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-18-1967
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: Oct 19, 1967
REGISTRAR'S SIGNATURE: Maurene Gene Overfield
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend an Original Certificate of Birth or Death

RECEIVED
OCT 30 1967
Bureau of Vital Statistics

State of Idaho } ss.
County of Lincoln

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Fredric Richard Mabbutt (Name on Original Certificate) who died (Was Born or Died) on Oct 15, 1967 (Date of Event)
in Jerome, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name of Deceased	Fredric Richard Mabbutt	Frederic Richard Mabbutt

Subscribed and sworn to before me this 28th day of October, 19 67

Notary Public, residing at Shoshone, Idaho
My commission expires April 9, 1969
(Seal)

Signed Francis M. Bergin
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Box 566 - Shoshone, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Lincoln

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 28th day of October, 19 67

Notary Public, residing at Shoshone, Idaho
My commission expires April 9, 1969
(Seal)

Signed Norma L. Bergin
(Signature of Any Credible Person)

SHOSHONE, IDAHO
(Street Address, City, State)

FORM DH. 60- 155

10-27-67 MB

Name of Deceased

Frederic Richard Nabbutt

Frederic Richard Nabbutt

died

Oct 15, 1957

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 1040
Reg. Dist. No. 440

RECEIVED
OCT 23 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome
b. CITY OR TOWN: Jerome 83338
c. LENGTH OF STAY (If outside corporate limits or non-resident): days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone 83352
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): FREDRIC
b. (Middle): RICHARD
c. (Last): MABBUTT

4. DATE OF DEATH: (Month) Oct. (Day) 15, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Aug. 6, 1915

9. AGE (In years last birthday): 52
IF UNDER 1 YEAR: Months: 2 Days: 9
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Materials Technician

10b. KIND OF BUSINESS OR INDUSTRY: Highway Dept.

11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: B. Ambrose Mabbutt
BIRTHPLACE: Linvill, Iowa

14. MOTHER'S MAIDEN NAME: Evelyn Meyers
BIRTHPLACE: Hailey, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 712-09-7580

17. INFORMANT'S OWN SIGNATURE: Helen G Mabbutt
ADDRESS: Shoshone 83352

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Ca of Kidney
INTERVAL BETWEEN ONSET AND DEATH: 8 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan., 1967, *to* Oct 15, 1967, *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at* 2:45 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): M.D
23b. ADDRESS: Box 6 Shoshone Idaho 83352
23c. DATE SIGNED: 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-18-1967
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: Oct 19, 1967
REGISTRAR'S SIGNATURE: Maurine Gene Duefield
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-163
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021 Certificate of Death

DUTIES:

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 31 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 21 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4530
Local Reg. No. 1039
Reg. Dist. No. 440

RECEIVED OCT 20 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 270
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 305 4th. Ave. East

3. NAME OF DECEASED (Type or Print)
a. (First): DORA
b. (Middle): JESSIE
c. (Last): BENTZINGER

4. DATE OF DEATH (Month) (Day) (Year): Oct. 15, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 28, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Clerk 25
10b. KIND OF BUSINESS OR INDUSTRY: Retail Dry Goods
11. BIRTHPLACE (State or foreign country): Schaller, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alfred Ames — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Alma Sears — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 07 6840
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Jerome, Idaho 83338

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

172X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Endometrial Carcinoma — 1 yr
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Bowel obstruction & fecal fistula 2 mos.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1961, to 15 Oct, 1967, that I last saw the deceased alive on 14 Oct, 1967, and that death occurred at 1:00A m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 385 1
23b. ADDRESS: Jerome Idaho 83338
23c. DATE SIGNED: 17 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Ada County Idaho

DATE REC'D BY LOCAL REG.: October 17, 1967
REGISTRAR'S SIGNATURE: Maurine Gene Overfield
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021 Acting Reg.
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 9 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4531
Local Reg. No. 1041
Reg. Dist. No. 440

BIRTH NO.

OCT 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: D.O.A. St. Benedict's Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 270
b. COUNTY: Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 421 4th. Ave. East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HUBERT	WILBUR	HODGETT	Oct. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Nov. 23, 1897	69		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Coal Mine Operator	Mining	Kewanee, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Absolom Hodgett	England	Ella -	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	333-07-3775	X Alice Lenora Hodgett	Jerome, Id

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — ?
DUE TO (c) ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetis mellitus — 8 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dead upon arrival *19__, to 19__, that I last saw the deceased alive on* no *19__, and that death occurred at* 5:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Reuben C. Matson	334 M.D.	Jerome Ida	10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Oct. 23, 1967	Pleasant View Cemetery	Kewanee, Illinois

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 23, 1967	Lenora M. Schurer	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: Hove Funeral Chapel

DEC 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Holsinger

Certificate of Death

STATE OF IDAHO

State File No. 4532
Local Reg. No. 1043
Reg. Dist. No. 440

BIRTH NO.

RECEIVED NOV 6 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270 003
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hosp. 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding 240
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding 83330
d. STREET ADDRESS (If rural, give location): 2221 So. Main St.

3. NAME OF DECEASED (Type or Print)
a. (First): Louise
b. (Middle): Rogers
c. (Last): Pounds

4. DATE OF DEATH: (Month) Oct. (Day) 27, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: Cau.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 4, 1888
9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): La Crosse, Wisc.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Milo James Pitkin — BIRTHPLACE: Fort Madison, Iowa
14. MOTHER'S MAIDEN NAME: Maria Louise Rogers — BIRTHPLACE: Glenn Falls, N.Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-24-7513
17. INFORMANT'S OWN SIGNATURE: Earl C. Pounds — ADDRESS: Gooding, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5371

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Acute & Chronic Urinary Retention — 10 days
DUE TO (c): Pulmonary Emphysema — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Exploratory laparotomy

19a. DATE OF OPERATION: 10/26/67
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-26, 1967, *to* death, 19____, *that I last saw the deceased alive on* 10-27, 1967, *and that death occurred at* 12:35 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Harold G. Holsinger MD — 240 (Degree or title)
23b. ADDRESS: Wendell, Ida. 83355
23c. DATE SIGNED: 11-3 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-31-1967
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: Nov. 3 1967
REGISTRAR'S SIGNATURE: Louella M. Deherer
25. EMBALMER: Roland S. Meyer
LICENSE NO.: E-424
FIRM NAME: Thompson Chapel - Gooding, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4533
Local Reg. No. 190
Reg. Dist. No. 120

RECEIVED OCT 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 000
b. CITY OR TOWN Worley
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 6 Miles S. E. of Worley 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Worley
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ray	Samuel	McGee	October 1, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Feb 17, 1897	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 84	Agriculture	Indiana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John W. McGee	Indiana	Florence Irwin	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW II 3	519-18-2252	Everett W McGee	Lake Orion, Mich

8164

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) auto accident - Crushed Chest. — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident 1	Highway 06	6 miles S.E. of Worley	Kootenai	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
m.		2 Ran into car

22. *I hereby certify that I attended the deceased from* Did not, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	583 (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood M.D. Coroner		Coeur d'Alene, Idaho	10-4-'67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	25. EMBALMER	LICENSE NO.
Burial 1	10-6-1967	Worley Cemetery	Worley Idaho	Bill Duff	E-439

DATE REC'D BY LOCAL REG. Oct. 5, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brown

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 13 1967

NOV 3 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Hughes

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4534
Local Reg. No. 192
Reg. Dist. No. 120

BIRTH NO.

OCT 19 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d Alene
c. LENGTH OF STAY (in this place): 6 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d Alene
d. STREET ADDRESS (If rural, give location): Route 2 Box 229 A

3. NAME OF DECEASED (Type or Print)
a. (First): Vera
b. (Middle): Maude
c. (Last): Brooks

4. DATE OF DEATH (Month) (Day) (Year): 10/3/67

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 21, 1899
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): at home 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Palouse, Washington
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME — BIRTHPLACE: Mallory Farley Lansing, Mich.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Maude Elizabeth Greer Topeka, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 533-10-4055
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Frank H Brooks — Coeur d Alene Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchogenic Carcinoma Lung Lt — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1967 *19*__, *to* 10-3, 1967, *that I last saw the deceased alive on* 10-3 1967, *and that death occurred at* 11:59 *m., from the causes and on the date stated above.*

23a. SIGNATURE 251 (Degree or title): [signature] 1
23b. ADDRESS: Coeur d'alene, Idaho
23c. DATE SIGNED: 10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 10/6/67
24c. NAME OF CEMETERY OR CREMATORY: Pullman Cemetery
24d. LOCATION (City, town, or county) (State): Pullman, Washington

DATE REC'D BY LOCAL REG.: Oct. 11, 1967
REGISTRAR'S SIGNATURE: Darraine K. Brush
25. EMBALMER: Wale E Kimball
LICENSE NO.: 259

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Kimball Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 25 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4535
Local Reg. No. 187
Reg. Dist. No. 12c

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 OCT 13 1967 113
b. CITY OR TOWN Coeur d'Alene | Bureau of Vital Statistics | c. LENGTH OF STAY (In this place) 13 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cd'A. Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 280 b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CdA. Homes
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Claude	E.	McCoy	Oct	3	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Widowed 2	9-4-1877	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Self	Mt Morris Ill.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Rigdon McCoy	Maryland	Helen Harper	Maryland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
None	None	None	Mrs. Flora Ellig	Smeletervill Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-21-62, 19___, *to* present, 19___, *that I last saw the deceased alive on* 10-3-67, 19___, *and that death occurred at* 12:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
1128 MD, 1	Coeur d'Alene Idaho	10-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-6-67	Forest	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 11, 1967	Lorraine K. Brush	Fred Noland	E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Thompson

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4536
Local Reg. No. 791
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 302
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

OCT 19 1967

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 28
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 112 Appleway

3. NAME OF DECEASED (Type or Print): a. (First) Marie b. (Middle) W. 101 c. (Last) McLeod

4. DATE OF DEATH: (Month) Oct. (Day) 5, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Oct. 1, 1896

9. AGE (In years last birthday): 71 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner-Manager 22

10b. KIND OF BUSINESS OR INDUSTRY: Maries Cafe

11. BIRTHPLACE (State or foreign country): Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unobtainable
BIRTHPLACE: Unobtainable

14. MOTHER'S MAIDEN NAME: Unobtainable
BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 540-26-6567

17. INFORMANT'S OWN SIGNATURE: Joe Webb, ADDRESS: North Bend, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4437

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Congestive Heart Failure — 3 months

DUE TO (c) Hypertensive Cardio Vascular Disease — 3 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 11, 1967, *to* October 5 1967, *that I last saw the deceased alive on* October 5, 1967, *and that death occurred at* 3:00a m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. C. Thompson 530 (Degree or title) MD

23b. ADDRESS: Coeur d'Alene, Idaho

23c. DATE SIGNED: 10-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-7-1967

24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Oct. 16, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Bill Neff — LICENSE NO.: E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4537
Local Reg. No. 208
Reg. Dist. No. 120

BIRTH NO.

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 202
b. CITY OR TOWN: Coeur d'Alene
c. LENGTH OF STAY (in this place): Few months
d. FULL NAME OF HOSPITAL OR INSTITUTION: 1119 North 4th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 45 Utah
b. COUNTY: 555 Salt Lake
c. CITY OR TOWN: Salt Lake City
d. STREET ADDRESS: 1349 South 5th East

3. NAME OF DECEASED (Type or Print): a. (First) Anna b. (Middle) Irene c. (Last) Welch

4. DATE OF DEATH: (Month) October (Day) 7 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 14, 1901
9. AGE (In years last birthday): 66 (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Illinois
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Michael Stephens — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Sarah Ann Tall — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 528-64-2147
17. INFORMANT'S OWN SIGNATURE: Claude W. Welch — ADDRESS: Coeur d'Alene Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory Failure — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Amyotrophic Lateral Sclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April, 1966 to Oct 7, 1967, that I last saw the deceased alive on Oct 3, 1967, and that death occurred at 8:45 a.m., from the causes and on the date stated above.

23a. SIGNATURE: Willis M. Lanham M.D. 632 (Degree or title)
23b. ADDRESS: Hayden Lake Idaho
23c. DATE SIGNED: 10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mt. Olivet Cemetery
24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: Oct. 18, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Glenn E. Browning
LICENSE NO.: E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4538
Local Reg. No. 188
Reg. Dist. No. 120

Certificate of Death

RECEIVED
OCT 13 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): 33 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 280
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spirit Lake
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Vivian
b. (Middle): C
c. (Last): Brott

4. DATE OF DEATH (Month) (Day) (Year): Oct 8 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb 20 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Hill City S. Dak
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Simon Auer — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Lilly Straw — BIRTHPLACE: S. Dak

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 507 14 8815
17. INFORMANT'S OWN SIGNATURE: D George Brott — ADDRESS: Spirit Lake Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, Rt. Lung — INTERVAL BETWEEN ONSET AND DEATH: 3-4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/5/67, 19__, *to* 10/8/67, 19__, *that I last saw the deceased alive on* 10/7/67, 19__, *and that death occurred at* 4:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Emm C. Fredrikson MD 177 1
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED: 10/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct 11 67
24c. NAME OF CEMETERY OR CREMATORY: Greenwood
24d. LOCATION (City, town, or county) (State): Spirit Lake Idaho

DATE REC'D BY LOCAL REG.: Oct. 11, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Gilbert Yates
LICENSE NO.: E-365

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 30 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 05 2000

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4539
Local Reg. No. 7897
Reg. Dist. No. 120

RECEIVED OCT 25 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 28/ Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28/
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 1007 Coeur d' Alene Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle) Kenneth 107
c. (Last) Lafrenz

4. DATE OF DEATH (Month) 10- (Day) 9 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never

8. DATE OF BIRTH 2-15-1952

9. AGE (In years last birthday) 15
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03

10b. KIND OF BUSINESS OR INDUSTRY School

11. BIRTHPLACE (State or foreign country) Lewiston, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wm. L. Lafrenz BIRTHPLACE Coeur d' Alene, Ida.

14. MOTHER'S MAIDEN NAME Jean Spencer BIRTHPLACE Lewiston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-56-0681

17. INFORMANT'S OWN SIGNATURE William L. Lafrenz ADDRESS Ida Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest — Repeated — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocarditis, involving conduction system — few days
DUE TO (c) probable virus — few days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Grand mal epilepsy — 4 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9, 1967, *to* 10-9, 1967, *that I last saw the deceased alive on* 10-9, 1967, *and that death occurred at* 9:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Barclay M.D. 026

23b. ADDRESS Coeur d'Alene

23c. DATE SIGNED 10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10-11-67

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Oct. 20 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Bill Lauff

LICENSE NO. E-439

FIRM NAME English Chapel - Coeur d' Alene,

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Mr. Daugherty

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4540
Local Reg. No. 213
Reg. Dist. No. 120

BIRTH NO.

NOV 1 1967

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): Star Route

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): A.
c. (Last): Shriner

4. DATE OF DEATH (Month) (Day) (Year): Oct. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept 26, 1907
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Gregory, South Dakota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Emanuel George Shriner — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Winnie Mae Dingest — BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 519-20-5562
17. INFORMANT'S OWN SIGNATURE: Mrs Charles Shriner — ADDRESS: Star Route Cd'A, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9-67, *19*___, *to* _____, *19*___, *that I last saw the deceased alive on* 10-10-67, *19*___, *and that death occurred at* 2:40 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: D. A. Daugherty 128 (Degree or title): MD
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-13-1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: Oct. 25, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: N. F. Riplinger Jr.
LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

NOV 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4541
Local Reg. No. 193
Reg. Dist. No. 120

Certificate of Death

RECEIVED
OCT 19 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 174
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 74 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 601 Lakeside

3. NAME OF DECEASED (Type or Print)
a. (First): Fritz
b. (Middle): O.
c. (Last): Perrenoud

4. DATE OF DEATH (Month) (Day) (Year): Oct. 11, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 10-17-1879
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Owner 22
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Norraigue, Switzerland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles F. Perrenoud, BIRTHPLACE: Switzerland
14. MOTHER'S MAIDEN NAME: Emma Vaatravers, BIRTHPLACE: Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 518-40-6738A
17. INFORMANT'S OWN SIGNATURE: Mrs. Emma Kobs, ADDRESS: Coeur d' Alene, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 week.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Senility
Chronic Gastritis — 6 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar., 1962, *to* Oct., 1967, *that I last saw the deceased alive on* Oct. 10, 1967, *and that death occurred at* 12:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Rex E. Henson, M.D. 225 1
23b. ADDRESS: Coeur d'Alene Idaho
23c. DATE SIGNED: Oct. 13, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-14-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Oct. 16, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Fred H. Noland
LICENSE NO.: E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 19 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4542
Local Reg. No. 214
Reg. Dist. No. 120

Certificate of Death

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY KOOTENAI 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) COEUR D'ALENE
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) KOOTENAI MEMORIAL HOSPITAL /01

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 288
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) WORLEY
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) VIRGIL
b. (Middle) N.
c. (Last) WESTERLUND

4. DATE OF DEATH (Month) 10 (Day) 15 (Year) 1967

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED 4
8. DATE OF BIRTH JUNE 26, 1911
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Malden, Wash.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Eric Westerlund — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME Christina E. Norbery — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-16-9538
17. INFORMANT'S OWN SIGNATURE Ernest Westerlund (SD) — ADDRESS Worley, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Right Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Left Hemo-pneumothorax — 12 days
DUE TO (c) Trauma — 12 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 3 1967 5p. m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Automobile

22. *I hereby certify that I attended the deceased from* 10/3, 1967, *to* 10/15, 1967, *that I last saw the deceased alive on* 10/15, 1967, *and that death occurred at* 8:30a. *m., from the causes and on the date stated above.*

23a. SIGNATURE B. E. Thompson 530 (Degree or title) MD
23b. ADDRESS 318 Elder Bldg. Coeur d'Alene,
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/18/67
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho

DATE REC'D BY LOCAL REG. Oct 24, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Huff
LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4543
Local Reg. No. 111
Reg. Dist. No. 12

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hosp. 10/

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 28 b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 808 Front St.

3. NAME OF DECEASED (Type or Print): a. (First) Manley b. (Middle) A. c. (Last) Stevens

4. DATE OF DEATH: (Month) Oct. (Day) 15, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 8-22-1906

9. AGE (In years last birthday): 61
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hydralic Special

10b. KIND OF BUSINESS OR INDUSTRY: Kaizer 21

11. BIRTHPLACE (State or foreign country): Watertown, S. Dakota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Arthur Stevens
BIRTHPLACE: Minn.

14. MOTHER'S MAIDEN NAME: Ella Thompson
BIRTHPLACE: S. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 504-09-3936

17. INFORMANT'S OWN SIGNATURE: Mrs. Celeste Stevens, Cd'A, Idaho
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 10 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertension — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

331X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/2/67, 1967, *to* 10/15, 1967, *that I last saw the deceased alive on* 10/14, 1967, *and that death occurred at* 6:25 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Wray Wilson MD 568 1
23b. ADDRESS: Coeur d Alene, Ida
23c. DATE SIGNED: 10/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-17-1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Park
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Oct. 18, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred H. Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4544
Local Reg. No. 2744
Reg. Dist. No. 120

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): Hours 404
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: 355 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane
d. STREET ADDRESS (If rural, give location): N4518 Stevens

3. NAME OF DECEASED (Type or Print)
a. (First): Merrill
b. (Middle): A. 101
c. (Last): Read

4. DATE OF DEATH: October 15, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 23, 1920

9. AGE (In years last birthday): 47
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Manager 26

10b. KIND OF BUSINESS OR INDUSTRY: Bearing Company

11. BIRTHPLACE (State or foreign country): The Dalles, Oregon

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Burnice A. Read
BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Lulu Viola Oakes
BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II 4

16. SOCIAL SECURITY NO.: 539-07-8105

17. INFORMANT'S OWN SIGNATURE: Mrs. Merrill Read
ADDRESS: N4518 Stevens Spokane, Wash.

8254

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Severe Crush Injury - Left chest
INTERVAL BETWEEN ONSET AND DEATH: 2½ hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify): 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 1006
21c. (CITY, TOWN, OR TOWNSHIP): 13 Near Post Falls (COUNTY): 28 Kootenai (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct 15 1967 4:00 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2
21f. HOW DID INJURY OCCUR?: Car accident

22. *I hereby certify that I attended the deceased from* Oct 15, 1967, *to* Oct 15, 1967, *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at* 6:35 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 313 Charles H. Hayden M.D.
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10-15-1967
24c. NAME OF CEMETERY OR CREMATORY: Thornhill-Geraghty
24d. LOCATION (City, town, or county) (State): Spokane Washington

DATE REC'D BY LOCAL REG.: Oct. 23, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Duff
LICENSE NO.: E-439
FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 1 1967
NOV 2 1967
NOV 8 1967
NOV 15 1967
JUN 26 1991
DEC 19 2001
MAY 18 2011

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Wood -

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4545
Local Reg. No. 115
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH — OCT 25 1967
a. COUNTY: Kootenai 287 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene — LENGTH OF STAY (in this place): 4 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 287 — b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 819 St. Maries

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Thomas	S.	Cope	Oct. 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed 2	Sept 16, 1875	92		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Merchant 22	Cope's Electric	Michigan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Francis Cope	Germany	Katherine Coyle	North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-36-2955A	Frances Cope	Ida. Coeur d'Alene

4918

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis, C.V.A. — several years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-1, 1967, *to* 10-16, 1967, *that I last saw the deceased alive on* 10-16, 1967, *and that death occurred at* 1 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
William T. Dodd, M.D. 512 (Degree or title)	Coeur d'alene Idaho	10-17-'67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-19-1967	St Thomas Cemetery	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 20, 1967	Lorraine K. Brush	Bill Neff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 1 1 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 1 6 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4546
Local Reg. No. 7
Reg. Dist. No. 120

RECEIVED OCT 25 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (If hospital or institution): 10
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 28
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
George	Quentin	Booth	October	16,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	July 30, 1919	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Painter 21	Rutledge Mill	Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
D.D. Booth	Ill.	Millicent Hays	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. II 4	516-16-6073	X Mrs George Booth	Idaho Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5391

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Pneumothorax — 3 days

DUE TO (c) Colon Interposition of Esophagus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Esophageal Stricture — 45 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Esophageal Stricture	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9/24, 1967, *to* 10/16, 1967, *that I last saw the deceased alive on* 10-16, 1967, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C E Thompson	530 MD	318 Elder Bldg. Coeur d Alene Idaho	10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-21-67	Forest Cemetery	Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 20 1967	Lorraine K. Brush	Bill Leuff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 5 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4547
Local Reg. No. 198
Reg. Dist. No. 120

BIRTH NO.

RECEIVED OCT 25 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 280 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
c. LENGTH OF STAY (If not in place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (Work) Liquor Store 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 280
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Willacyne
b. (Middle):
c. (Last): Scott

4. DATE OF DEATH (Month) (Day) (Year): Oct. 17, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 9-2-1920
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 01
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 523-12-4511
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Dale Scott, Post Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH: seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-15, 1967, *to* 10-17, 1967, *that I last saw the deceased alive on* 9-28, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Barclay M.D. 026
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED: 10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-20-1967
24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
24d. LOCATION (City, town, or county) (State): Post Falls, Idaho

DATE REC'D BY LOCAL REG.: Oct. 20, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Fred H. Noland — LICENSE NO.: E-493

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Yates Funeral Home

DUTIES:

DEC 27 1974

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 16 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4548
Local Reg. No. 196
Reg. Dist. No. 120

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 40 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 924 6th. St. (Home) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 281
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 924 6th. St.

3. NAME OF DECEASED (Type or Print)
a. (First) Otto
b. (Middle) H.
c. (Last) Heisel

4. DATE OF DEATH (Month) Oct. (Day) 18, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 4-17-1884
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Wisconsin
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Fred Heisel — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-20-0287A
17. INFORMANT'S OWN SIGNATURE Mrs. Hazel Heisel, ADDRESS Coeur d' Alene, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 30 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 15 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1945, *to* 10/18, 1967, *that I last saw the deceased alive on* 10/18, 1967, *and that death occurred at* 1230 m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 144 (Degree or title) M.D.
23b. ADDRESS Coeur d alene
23c. DATE SIGNED 10/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 21, 67
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, Idaho (State)

DATE REC'D BY LOCAL REG. Oct. 20, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred H. Noland — LICENSE NO. E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Hughes

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4549
Local Reg. No. 209
Reg. Dist. No. 120

BIRTH NO.

NOV 1 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 204
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): 4 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Coeur d'Alene Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): Coeur d'Alene Homes

3. NAME OF DECEASED (Type or Print)
a. (First): Karoline
b. (Middle): J.
c. (Last): Nelson

4. DATE OF DEATH (Month) (Day) (Year): Oct. 18, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Jan. 8, 1881
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unobtainable — BIRTHPLACE: ------
14. MOTHER'S MAIDEN NAME: Unobtainable — BIRTHPLACE: --------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Clarence A. Nelson — ADDRESS: Spokane, Wash

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart disease
DUE TO (c) 15 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1959, 19__ *to* 10-18, 1967, *that I last saw the deceased alive on* 10-17, 1967, *and that death occurred at* 12:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): N Hughes MD 251 1
23b. ADDRESS: Coeur d'Alene, Idaho
23c. DATE SIGNED: 10-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 10-21-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.: Oct. 25, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: N. F. Riplinger Jr.
LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

moseley

Certificate of Death

STATE OF IDAHO

State File No. 4550
Local Reg. No. 204
Reg. Dist. No. 120

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur D'Alene
c. LENGTH OF STAY (in this place): 8 days 30

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 28
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 822 6th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Florence
b. (Middle): 101
c. (Last): Garrels

4. DATE OF DEATH (Month) (Day) (Year): October 18, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 15, 1888

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Colorado

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sherman Turner
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Minnie Onesider
BIRTHPLACE: Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-03-0907

17. INFORMANT'S OWN SIGNATURE: C.O. Garrels
ADDRESS: Coeur d'Alene, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

360X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac failure with uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Diabetes and arteriosclerotic chronic myocarditis with decompensation — 20 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/28, 1965, *to* 10/18, 1967, *that I last saw the deceased alive on* 10/18, 1967, *and that death occurred at* 11:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): H. Don Moseley, M. D.
H. Don Moseley M.D.

23b. ADDRESS: Coeur d'Alene, Idaho

23c. DATE SIGNED: 10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-21-1967

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Oct 26, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: D. M. Riplinger, Jr.
LICENSE NO.: E-397
FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Wood

Certificate of Death

STATE OF IDAHO

State File No. 4551
Local Reg. No. 203
Reg. Dist. No. 120

BIRTH NO.

RECEIVED NOV 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 28
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): 708 Williams

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
John	W.	Ferger	Oct. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 11, 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Plumber 21	Private Contractor	South Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dennis Ferger	Not available	Not available	--------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE (Sp)	ADDRESS
No	None	519-03-2883	Kenneth Ferger (Sp)	Post Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Did not, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
William T. Wood, M.D. 583 (Degree or title) Coroner	Coeur d'Alene, Idaho	10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-23-1967	Evergreen Cemetery	Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 24, 1967	Lorraine K. Brush	Bill Cauff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4552
Local Reg. No. 208
Reg. Dist. No. 120

Certificate of Death

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 — 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 721 Empire

3. NAME OF DECEASED (Type or Print)
a. (First): Oscar
b. (Middle): W. 101
c. (Last): Nelson

4. DATE OF DEATH (Month) 10 (Day) 20 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 7-10-1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance 24
10b. KIND OF BUSINESS OR INDUSTRY: Own Agency
11. BIRTHPLACE (State or foreign country): Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Nelson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Ingeborg Olson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-22-9799
17. INFORMANT'S OWN SIGNATURE: Noreen W. Nelson — ADDRESS: Coeur d'Alene Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Head Injury - Skull Fracture — INTERVAL BETWEEN ONSET AND DEATH: 6-7 Hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Auto Accident — 6-7 Hours
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 281 (STATE): Coeur D' Alene Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Oct. 20, 1967-7:30 A.
21e. INJURY OCCURRED: WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 2-Car Accident

22. *I hereby certify that I attended the deceased from* 1961, 19__, *to* 10/20/67, 19__, *that I last saw the deceased alive on* 10/20/67, 19__, *and that death occurred at* 3:20 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Lynn C. Fredrikson MD. 177 (Degree or title)
23b. ADDRESS: Coeur d' Alene, Idaho
23c. DATE SIGNED: 10/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-24-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.: Oct 27, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Duff — LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

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3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS By Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4553
Local Reg. No. 372
Reg. Dist. No. 120

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 102 Theresa-Fernan Village

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 102 Theresa-Fernan Village

3. NAME OF DECEASED (Type or Print): a. (First) Nell; b. (Middle) E. 000; c. (Last) Schroeder

4. DATE OF DEATH: (Month) 10 (Day) 21 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 1-2-1887

9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laundry operator 01

10b. KIND OF BUSINESS OR INDUSTRY: CDA Laundry

11. BIRTHPLACE (State or foreign country): MO.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Durdy — BIRTHPLACE: Mo.

14. MOTHER'S MAIDEN NAME: Minnie Bedell — BIRTHPLACE: MO.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: X Dorothy M. Schroeder — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral-Vascular accident 331X — INTERVAL BETWEEN ONSET AND DEATH: Hrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) accident

DUE TO (c) Gen. + cerebral Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10/65, *to* 10/24, 1967, *that I last saw the deceased alive on* 10/21, 1967, *and that death occurred at* 7:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Rev. Alex Ott (Degree or title): III D.D. — **23b. ADDRESS**: Coeur d Alene — **23c. DATE SIGNED**: 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 10-25-1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Forest Cemetery — **24d. LOCATION** (City, town, or county) (State): Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.: Oct. 25, 1967 — **REGISTRAR'S SIGNATURE**: Lorraine K. Brush

25. EMBALMER: Bill Neff — **LICENSE NO.**: E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 9 1967

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DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4554
Local Reg. No. 219
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 111 S. 12th St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Joseph	Toliver	Perry	10	21	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	8-22-1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber 21
10b. KIND OF BUSINESS OR INDUSTRY: Private Business
11. BIRTHPLACE (State or foreign country): Troy, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Perry — BIRTHPLACE: Unobtainable
14. MOTHER'S MAIDEN NAME: Addie unobtainable — BIRTHPLACE: unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): W.W. 1 3
16. SOCIAL SECURITY NO.: 519-36-3038A
17. INFORMANT'S OWN SIGNATURE: Francis E Perry — ADDRESS: Ida., Coeur d'Alene

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Superior mesenteric a. thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASHD
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4200

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-22, 1967, *to* 10-21, 1967, *that I last saw the deceased alive on* 10-21, 1967, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R H [illegible] MD
23b. ADDRESS: Hayden Lake Idaho
23c. DATE SIGNED: 10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-24-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene Ida.

DATE REC'D BY LOCAL REG.: Oct 30, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Lauff
LICENSE NO.: E-397
FIRM NAME: English Chapel-Coeur d'ALene

Federal Security Agency
United States Public Health Service
Form DH-63021

NOV 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4555
Local Reg. No. 202
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 1 1967 000 Bureau of Vital Statistics

1. PLACE OF DEATH 281
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CDA HOmes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 281
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print)
a. (First) Stella
b. (Middle) M.
c. (Last) Enders

4. DATE OF DEATH (Month) 10 (Day) 22 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 9-22-1881
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Adair, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Francis M. Waggoner — BIRTHPLACE Virginia
14. MOTHER'S MAIDEN NAME Ida Y. Dwiggins — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-60-8198
17. INFORMANT'S OWN SIGNATURE Eugene H Enders — ADDRESS Post Falls, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-20, 1967, *to* 10-22, 1967, *that I last saw the deceased alive on* 10-20, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Frank Barclay MD 025 (Degree or title)
23b. ADDRESS Coeur d'Alene Ida
23c. DATE SIGNED 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-25-1967
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, Ida. (State)

DATE REC'D BY LOCAL REG. Oct. 25, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Cluff — LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: English Chapel-Coeur d' Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4556
Local Reg. No. 210
Reg. Dist. No. 120

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 NOV 1 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): E. of Coeur d'Alene
c. LENGTH OF STAY (in this place): Bur. of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunny Side District 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 402
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): #4 Front Street

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): Seymore
c. (Last): Patton

4. DATE OF DEATH (Month) (Day) (Year): Oct. 22 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov. 4, 1900
9. AGE (In years last birthday): 57 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07
10b. KIND OF BUSINESS OR INDUSTRY: Mining
11. BIRTHPLACE (State or foreign country): Kansas City, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Patton — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Katherine Seymore — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 567-09-8142
17. INFORMANT'S OWN SIGNATURE: Irene Rice, Coeur d'Alene Ida. — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Wood M.D. Coroner 4 583
23b. ADDRESS: Coeur d'Alene Idaho
23c. DATE SIGNED: 10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery
24d. LOCATION (City, town, or county) (State): Coeur D Alene Idaho

DATE REC'D BY LOCAL REG.: Oct 27, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: [signature] Jr
LICENSE NO.: E-397
FIRM NAME: Cornells Funeral HOme Wallace Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4557
Local Reg. No. 207
Reg. Dist. No. 126

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
DURATION OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hosp. 181

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 380
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): Rt. #1 137 A.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Grace		Hunt	Oct. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	11-7-1899	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Evanston, Ill.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard Wilson	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	None	Kenneth Hunt	Sunnyvale, Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 18 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive CardioVascular Disease — 10 years
DUE TO (c) Diabetes Mellitus — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct. 22, 1967, *to* Oct. 23, 1967, *that I last saw the deceased alive on* Oct. 23, 1967, *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C.E. Thompson	530 MD	318 Elder Bldg. Coeur d'Alene, Idaho	10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	10-27-1967	Hazen & Jaeger	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 25, 1967	Lorraine K. Brush	Fred H. Noland	E-493

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Yates Funeral Home

DUTIES:

NOV 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 10 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4558
Local Reg. No. 206
Reg. Dist. No. 120

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 725 2Nd. St.

3. NAME OF DECEASED (Type or Print): a. (First) Marcella b. (Middle) G. c. (Last) Hill

4. DATE OF DEATH: (Month) Oct. (Day) 23, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 3-29-1904

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): X-ray Ass't. 21

10b. KIND OF BUSINESS OR INDUSTRY: Koot. Mem. Hosp

11. BIRTHPLACE (State or foreign country): Norfolk, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James C. Brown
BIRTHPLACE: Redfield, Iowa

14. MOTHER'S MAIDEN NAME: Mary Ann Totten
BIRTHPLACE: Skidmore, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 550-10-7493

17. INFORMANT'S OWN SIGNATURE: Mrs. Ada Johnson
ADDRESS: Coeur d' Alene, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Fat Embolization — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fractured right pelvis — 3.5 hours
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Right hemo-pneumo thorax — 35 hours

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) 23 **(COUNTY)** 280 **(STATE)**: Kootenai Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10-21-67 5 p. m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-21, 19 67, *to* 10-23, 19 67, *that I last saw the deceased alive on* 10-23, 19 67, *and that death occurred at* 4:15 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: C E Thompson (Degree or title) 530 MD

23b. ADDRESS: 318 Elder Bldg, Coeur d Alene Idaho

23c. DATE SIGNED: 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 10-25-1967

24c. NAME OF CEMETERY OR CREMATORY: Golden Gate National

24d. LOCATION (City, town, or county) (State): San Burno, Californai

DATE REC'D BY LOCAL REG.: Oct 25 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred H. Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4559
Local Reg. No. 205
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 2 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 718 N. 10th St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 205 Indiana

3. NAME OF DECEASED (Type or Print)
a. (First): Carl
b. (Middle):
c. (Last): Haggerty

4. DATE OF DEATH (Month) (Day) (Year): 10-24- 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 3-30-1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumbering
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John A. Haggerty — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Saphronia Savage Grant Co., Wisc. — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-03-9181
17. INFORMANT'S OWN SIGNATURE: Mrs Irene Cook, — ADDRESS: Coeur d'alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 583 (Degree or title): William T. Wood M.D. Coroner
23b. ADDRESS: 4 Coeur d' alene, Idaho
23c. DATE SIGNED: 10-27-'67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-30-1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Oct 27, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: N. F. Riplinger Jr.
LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED NOV 6 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4560
Local Reg. No. 217
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur D'Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur D'Alene
d. STREET ADDRESS (If rural, give location): Coeur D'Alene Homes

3. NAME OF DECEASED (Type or Print)
a. (First): HARRY
b. (Middle): ORLANDO
c. (Last): COOK

4. DATE OF DEATH (Month) (Day) (Year): Oct. 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 7, 1888
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Baker 21
10b. KIND OF BUSINESS OR INDUSTRY: Bakery
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Cook — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. I 3
16. SOCIAL SECURITY NO.: 519-18-2611A
17. INFORMANT'S OWN SIGNATURE: John F. Cook — ADDRESS: Alaska Douglas

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Myocardial failure — 1 day
DUE TO (c): Cardiac arrests — 1 day

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Chronic bronchitis — Chronic
sub-capital fracture femur — 1 week

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: subcapital fracture femur; dislocation prostlus
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-18, 1967, *to* 10-25, 1967, *that I last saw the deceased alive on* 10-25, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William George Moore M.D. 798
23b. ADDRESS: 220 Eilder Bldg
23c. DATE SIGNED: 11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Oct. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Forest
24d. LOCATION (City, town, or county) (State): Coeur D'Alene, Idaho

DATE REC'D BY LOCAL REG.: 11-6-67
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Don English — LICENSE NO. E-337

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: MAISEL FUNERAL CHAPEL

NOV 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 02 1997

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4561
Local Reg. No. 220
Reg. Dist. No. 120

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 / 05
b. CITY OR TOWN Coeur d' Alene
LENGTH OF STAY (in this place) 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor 26

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28 /
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 719 Sherman
d. STREET ADDRESS (If rural, give location) Coeur d' Alene, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) Ethel b. (Middle) Marie c. (Last) StClair
4. DATE OF DEATH (Month) Oct. (Day) 26, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 12, 1884
9. AGE (In years last birthday) 83
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown Peterson
BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ------
(If yes, give war or dates of service) ---------
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE, ADDRESS x Mrs Hazel N. George, 1009 24th Sacramento, Cal

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) General senility and debility — INTERVAL BETWEEN ONSET AND DEATH 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral vascular accident — 5 years
DUE TO (c) Generalized arteriosclerosis — Year
Urinary tract infection — 1 week
Osteo arthritis, Severe — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 25, 1962, to Oct 26, 1967, *that I last saw the deceased alive on* Sept 28, 1967, *and that death occurred at* 7:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 568 W. Wray Wilson, MD.
23b. ADDRESS Coeur d'Alene, Idaho
23c. DATE SIGNED 10/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE 10-28-67
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. 11-6-67
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Leff
LICENSE NO. E-439
FIRM NAME: English Chapel - Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 17 1977

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4562
Local Reg. No. 201
Reg. Dist. No. 120

67-10991
BIRTH NO.

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY IN (this place) 2 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 320 S. 17th. St.

3. NAME OF DECEASED (Type or Print): a. (First) Donald b. (Middle) P. c. (Last) Broesch

4. DATE OF DEATH: (Month) Oct. (Day) 27, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Nevermarried

8. DATE OF BIRTH: 10-27-1967

9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours 2 / Min. 28

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Coeur d' Alene, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Duane Broesch BIRTHPLACE: Spokane, Wash.

14. MOTHER'S MAIDEN NAME: Connie Williams BIRTHPLACE: Hawaii

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NO

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE: Duane Broesch ADDRESS: Coeur d' Alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Premature — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) 5 mo Gestation
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* Oct 27, 19__, *and that death occurred at* 7:28 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD
23b. ADDRESS 317 Midtown Blvd.
23c. DATE SIGNED Oct 27

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-30-67
24c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Oct. 27, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred H. Noland
LICENSE NO. E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Daugherty

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4563
Local Reg. No. 221
Reg. Dist. No. 120

BIRTH NO.

NOV 6 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Kootenai 28 / 30

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene

c. LENGTH OF STAY (in this place): 1 day

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 28 / b. COUNTY: Kootenai

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene

d. STREET ADDRESS (If rural, give location): 309 Emma Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Richard b. (Middle) D. c. (Last) Tyson

4. DATE OF DEATH (Month) (Day) (Year): October 28, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 21, 1897

9. AGE (In years last birthday): 70 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Tyson — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Mary J. East — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-40-6842

17. INFORMANT'S OWN SIGNATURE: Mrs. Richard Tyson ADDRESS: Coeur d'Alen

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-16-64, 19____, *to* present, 19____, *that I last saw the deceased alive on* 10-2-67, 19____ *and that death occurred at* 7:10 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. A. Daugherty M.D.

23b. ADDRESS: Coeur d'Alene, Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10-31-1967

24c. NAME OF CEMETERY OR CREMATORY: Woodwawn Cemetery

24d. LOCATION (City, town, or county) (State): St Maries, Idaho

DATE REC'D BY LOCAL REG.: 11-6-67

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Bill Duff — LICENSE NO.: E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Barclay

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4564
Local Reg. No. 215
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 280 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hayden Lake
c. LENGTH OF STAY (in this place) 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Su Haven Hursing Home 252

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 281
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 1209 13th Street

3. NAME OF DECEASED (Type or Print)
a. (First) Jospeh
b. (Middle) J.
c. (Last) Bucher

4. DATE OF DEATH (Month) (Day) (Year) Oct. 29, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH April 11, 1894
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Logger 17
10b. KIND OF BUSINESS OR INDUSTRY Pack River Lumber
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Julius Bucher — BIRTHPLACE France
14. MOTHER'S MAIDEN NAME Felicia Adoix — BIRTHPLACE France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 536-03-1167
17. INFORMANT'S OWN SIGNATURE Coeur d'Alene — ADDRESS Idaho
X Bernadine L. Currie

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 da.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. art. sclerotic cardio-vasc. disease 10 yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I ~~attended~~ did not the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on* 3-16, 1965, *and that death occurred at* 9:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Frank Barclay MD 025 (Degree or title)
23b. ADDRESS Coeur d'Alene, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-31-1967
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho

DATE REC'D BY LOCAL REG. 11-6-67
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER N. F. Ripplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4565
Local Reg. No. 222
Reg. Dist. No. 120

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 28 Kootenai
b. CITY OR TOWN Harrison Route 1
c. LENGTH OF STAY (in this place) 505 Few min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) William Lavigne Ranch 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 28 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harrison
d. STREET ADDRESS (If rural, give location) Route 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Hans	J.	Fabricius	October 30 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 3, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ranching 04	Livestock	Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hans Fabricius	Denmark	Caroline Tovel	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-24-0677	Anna M Fabricius	Harrison

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* Oct 30, 1967, *that I last saw the deceased alive on* DOA, 19___, *and that death occurred at* 8:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B.A. Rapp 428 M.D.	St. Maries, Ida.	11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-2-1967	Woodlawn Cemetery	St. Maries, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 16, 1967	Lorraine K. Brush	Gerald E Browning	E-411

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4566 129
Local Reg. No. 200
Reg. Dist. No.

Certificate of Death

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 33 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Idaho
b. COUNTY: 555 Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Asotin
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Harle
b. (Middle): Swaim
c. (Last): Adams

4. DATE OF DEATH (Month) (Day) (Year): Oct. 3, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 9, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rural Letter Carrier
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Post Office
11. BIRTHPLACE (State or foreign country): Canyon City, Colorado
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John C. Adams — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Sophronia Swain — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-52-5531
17. INFORMANT'S OWN SIGNATURE: Stella Adams — ADDRESS: Asotin, Wn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 1588 Sarcoma, peritoneal cavity — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 7, 1967, *to* Oct 3, 1967, *that I last saw the deceased alive on* Aug 3, 1967, *and that death occurred at* 9:45 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Claude H. West 691 (Degree or title) MDI
23b. ADDRESS: Pullman Wash
23c. DATE SIGNED: 10-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 10-19-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Fred J. Nelson
LICENSE NO.: 504

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 24 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 21 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 1304567
Local Reg. No. 200
Reg. Dist. No.

67-10095

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 291
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 416 North Blaine

3. NAME OF DECEASED (Type or Print)
a. (First): Baby Boy
b. (Middle): Kalbfleisch
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): October 4, 1967

5. SEX: Male
6. COLOR OR RACE: W'ite
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant
8. DATE OF BIRTH: October 3, 1967
9. AGE (In years last birthday): If under 1 year: Months / Days 1; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wayne Kalbfleisch
BIRTHPLACE: Twin Falls, Idaho
14. MOTHER'S MAIDEN NAME: Jeanne Agidius
BIRTHPLACE: Kodiak, Alaska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Wayne S. Kalbfleisch
ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

750X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Anencephalic Monster — INTERVAL BETWEEN ONSET AND DEATH: 26 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 3, 1967, *to* Oct. 4, 1967, *that I last saw the deceased alive on* Oct 4, 1967, *and that death occurred at* 11:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 058 (Degree or title) M.D.
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: October 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Grtiman Hospital
24d. LOCATION (City, town, or county) (State): Moscow, Latah, Idaho

DATE REC'D BY LOCAL REG.: 10-19-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Donald Ward
LICENSE NO.: E-380
FIRM NAME: Shorts Funeral Chapel, Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 1314568
Local Reg. No. 200
Reg. Dist. No.

67-2678 RECEIVED OCT 20 1967 Bureau of Vital Statistics
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 29
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 712 S. Harrison

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Kevin	Eugene	Bertholf	Oct. 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	March 10, 1967		7	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
02	at home	Moscow, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gerald Bertholf	Tensed, Idaho	Clara Mae Little	Ider, Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	Gerald Bertholf	Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	9240 Accidental Strangulation	Minutes
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
XX 1	Home 01	Moscow	Latah	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Oct 8, 1967 - 8:30PM	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Head & neck caught between head of bed & mattress.

22. *I hereby certify that I attended the deceased from* Oct. 8, 1967, 19___, to ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 8:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Orville Brooks MD Co. Coroner	Moscow, Idaho	10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 12, 1967	Dusty, Wn. Cemetery	Dusty Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-19-67	Sherrill Ann Williams	Donald Ward	E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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b-67-2678

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 24 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4569
Local Reg. No. 132
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman General Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1507 - 17th Street

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLES
b. (Middle): EDWARD
c. (Last): GLASBY

4. DATE OF DEATH (Month) (Day) (Year): 15 October 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 10 January 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk 08
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Post Office
11. BIRTHPLACE (State or foreign country): Haddam, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William W. Glasby — BIRTHPLACE: Maryland
14. MOTHER'S MAIDEN NAME: Sarah E. Johnson — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 22 1225A
17. INFORMANT'S OWN SIGNATURE: Letitia I. Glasby — ADDRESS: Lewiston, Idaho 1507-17th St.

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: —

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 1-10, 1952, *to* 10-14, 1967, *that I last saw the deceased alive on* 10-14, 1967, *and that death occurred at* 12:25AM *m., from the causes and on the date stated above.*

23a. SIGNATURE 149 (Degree or title): Edward W. Wann M.D.
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 10.20.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 15 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, NezPerceCo., Idaho

DATE REC'D BY LOCAL REG.: Oct 23, 1967
REGISTRAR'S SIGNATURE: Cheryl Ann Williams by Wayne R. Weiskari deputy
25. EMBALMER: L. E. DeBaun — Malcoms Brower-Wann Memorial Chapel
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

OCT 25 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4570
Local Reg. No. 133
Reg. Dist. No. 200

BIRTH NO. RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 29 Latah — OCT 30 1967 — 162
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt. 1 at home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 29 — b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Wallace	Wilbert	Wallen	Oct. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Feb. 12, 1905	62		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Moscow, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Wallen	Sweden	Anna Frei	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-42-2367	X Mrs Flora Wallen	Moscow

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 2:00A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. E. Marineau, M.D. 328	729 West 3rd, Moscow, Idaho	10/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 19, 1967	Moscow Cemetery	Moscow, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-27-67	Cheryl Ann Wilkins	Donald Ward	E-80

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Chapel

OCT 31 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SDH APR 07 2017

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4571
Local Reg. No. 134
Reg. Dist. No. 200

RECEIVED OCT 30 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 29 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Viola
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) Violet b. (Middle) Modest c. (Last) Reiber

4. DATE OF DEATH (Month) (Day) (Year) Oct 16 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Sept 16, 1906
9. AGE (In years last birthday) 61
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Williamsburg, W. Va.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-44-5150
17. INFORMANT'S OWN SIGNATURE X Henry S. Reiber
ADDRESS Viola, Ida.

4200

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolis — INTERVAL BETWEEN ONSET AND DEATH 18 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — years
DUE TO (c) Arteriosclerosis, general — year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1960, *to* Oct 16, 1967, *that I last saw the deceased alive on* Oct 16, 1967, *and that death occurred at* 9:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE W. Rodams, M.D. (Degree or title)
23b. ADDRESS Moscow, Idaho
23c. DATE SIGNED 10/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 20, 1967
24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery
24d. LOCATION (City, town, or county) Moscow (State) Idaho

DATE REC'D BY LOCAL REG. 10-27-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER Donald Ward
LICENSE NO. E-80
FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4572
Local Reg. No. 135
Reg. Dist. No. 200

BIRTH NO.

RECEIVED
OCT 30 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29 / 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Jacob c. (Last) Clark

4. DATE OF DEATH (Month) (Day) (Year): Oct. 16, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 15, 1919

9. AGE (In years last birthday): 48 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY: Tractor

11. BIRTHPLACE (State or foreign country): Juliaetta, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William M. Clark — BIRTHPLACE: Juliaetta, Ida.

14. MOTHER'S MAIDEN NAME: Alice Mae Eckman — BIRTHPLACE: Troy, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): W. W. 2

16. SOCIAL SECURITY NO.: 519389158

17. INFORMANT'S OWN SIGNATURE: X Marion Clark — ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Stomach — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 4:23 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Jared C. Valder MD — **23b. ADDRESS**: Moscow Idaho — **23c. DATE SIGNED**: 10-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Oct. 18, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Moscow Cemetery — **24d. LOCATION** (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 10-21-67 — **REGISTRAR'S SIGNATURE**: Cheryl Ann Williams — **25. EMBALMER**: Fred J. Nelson — **LICENSE NO.**: E-504

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 31 1967

FEB 23 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4573
Local Reg. No. 137
Reg. Dist. No. 200

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 291 Latah 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 291
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 335 North Almon

3. NAME OF DECEASED (Type or Print)
a. (First): Eva
b. (Middle): Kessler
c. (Last): Phillippi

4. DATE OF DEATH (Month) (Day) (Year): October 19, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: November 27, 1893
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Homemaker
11. BIRTHPLACE (State or foreign country): Hamlin, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Joshua Tucker — BIRTHPLACE: Hamlin, Kansas
14. MOTHER'S MAIDEN NAME: Olive Mary Lichty — BIRTHPLACE: Ashton, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-09-5813
17. INFORMANT'S OWN SIGNATURE: X Mrs. Fontella Tocon — ADDRESS: Moscow, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Massive Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 2 p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. P. Marineau, M. D. 328
23b. ADDRESS: 129 West 3rd, Moscow, Idaho
23c. DATE SIGNED: 10/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10-21-1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow, Cemetery
24d. LOCATION (City, town, or county) (State): Moscow, Latah Idaho

DATE REC'D BY LOCAL REG.: 11-3-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Fred J. Nelson — LICENSE NO. E-504
FIRM NAME: Short's Funeral Chapel, Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a ~~person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4574
Local Reg. No. 136
Reg. Dist. No. 200

RECEIVED OCT 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 291 Latah 318
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latah Co. Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 290
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Princeton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Mabel
b. (Middle)
c. (Last) Jones

4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 11, 1882
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Huron, Indiana
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME John Hendrickson — BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Sarah Jane Dorsett — BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Mrs. George McCleerey — ADDRESS Princeton Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Dehydration & Malnutrition — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Cerebral Thrombosis — 1 wk
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Bleeding Duodenal Ulcer — 8 mos.
Chronic Pyelitis — yrs.
Anemia, Secondary — 3 mos.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1964, *to* Oct. 20, 1967, *that I last saw the deceased alive on* Oct. 20, 1967, *and that death occurred at* 8:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 056 (Degree or title) MD
23b. ADDRESS Moscow, Idaho
23c. DATE SIGNED Oct. 23, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-24-1967
24c. NAME OF CEMETERY OR CREMATORY Potlatch Cemetery
24d. LOCATION (City, town, or county) (State) Potlatch, Idaho

DATE REC'D BY LOCAL REG. 10-27-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER [signature]
LICENSE NO. E269

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Kimball Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4575
Local Reg. No. 138
Reg. Dist. No. 200

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 307
b. CITY OR TOWN Moscow
(If outside corporate limits, write RURAL and give township)
DURATION OF STAY (in this place) 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Grittman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 28
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 703 3rd St.

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) E. c. (Last) Heyn

4. DATE OF DEATH (Month) 10 (Day) 21 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH 7-20-1905

9. AGE (In years last birthday) 62 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor 26

10b. KIND OF BUSINESS OR INDUSTRY Kaiser Alum.

11. BIRTHPLACE (State or foreign country) Wisc.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Heyn BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Mary Pingle BIRTHPLACE Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-16-9101

17. INFORMANT'S OWN SIGNATURE Howard D Heyn ADDRESS Idaho Coeur d'alene,

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

345X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Sclerosis — INTERVAL BETWEEN ONSET AND DEATH 4 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Oct. 10, 1967, *that I last saw the deceased alive on* Oct. 10, 1967, *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward L Bass MD (Degree or title)
23b. ADDRESS Professional Bldg. Moscow
23c. DATE SIGNED 10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 10-22-1967
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Ida.

DATE REC'D BY LOCAL REG. 11-3-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER Howard Ward
LICENSE NO. E-380

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4576
Local Reg. No. 139
Reg. Dist. No. 200

Certificate of Death

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 291 Latah 313
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (If in hospital or institution) 13 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 290
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Princeton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) George
b. (Middle) Montgomery
c. (Last) Wasson

4. DATE OF DEATH (Month) (Day) (Year) Oct. 23, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 6-8-1874
9. AGE (In years last birthday) 93 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant 22
10b. KIND OF BUSINESS OR INDUSTRY Grocery Store
11. BIRTHPLACE (State or foreign country) Lockhaven, Penn.
12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME William H. Wasson — BIRTHPLACE Penn.
14. MOTHER'S MAIDEN NAME Harriet C. Bitner — BIRTHPLACE Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-24-3340
17. INFORMANT'S OWN SIGNATURE Mrs Dillon Wasson — ADDRESS Princeton Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Artery Disease — INTERVAL BETWEEN ONSET AND DEATH years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 12, 1967 *to* Oct 23, 1967, *that I last saw the deceased alive on* Oct 23, 1967, *and that death occurred at* 11:20 AM *from the causes and on the date stated above.*

23a. SIGNATURE Claudett Neely MD 691 (Degree or title)
23b. ADDRESS Pullman Washington
23c. DATE SIGNED 10-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-26-1967
24c. NAME OF CEMETERY OR CREMATORY Fairmount Mem. Park
24d. LOCATION (City, town, or county) (State) Spokane, Wash.

DATE REC'D BY LOCAL REG. 11-3-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER H. E. Kimball
LICENSE NO. E269

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Kimball Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4577
Local Reg. No. 140
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 291
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 515 South Hayes

3. NAME OF DECEASED (Type or Print)
a. (First) Alexander
b. (Middle) Burnet
c. (Last) McDonald

4. DATE OF DEATH (Month) (Day) (Year) October 25, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH August 8, 1909
9. AGE (In years last birthday) 58 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) School Administration
10b. KIND OF BUSINESS OR INDUSTRY 12 Education
11. BIRTHPLACE (State or foreign country) Byesville, Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John R. McDonald BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME Elizabeth Burnet BIRTHPLACE Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-46-6304
17. INFORMANT'S OWN SIGNATURE X [signature] ADDRESS [signature]

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 13 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1962, 19__, *to* Oct 25, 1967, *that I last saw the deceased alive on* Oct 25, 1967, *and that death occurred at* 9:07 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE 001 (Degree or title) W. Adams, M.D.
23b. ADDRESS Moscow, Idaho
23c. DATE SIGNED 10/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2
24b. DATE 10-30-67
24c. NAME OF CEMETERY OR CREMATORY Hazen-Jaeger Crematory
24d. LOCATION (City, town, or county) (State) Spokane Spokane Washington

DATE REC'D BY LOCAL REG. 11-3-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER Donald Ward
LICENSE NO. E-380
FIRM NAME: Short's Funeral Chapel Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4578
Local Reg. No. 141
Reg. Dist. No. 200

BIRTH NO.

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29 128
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 28, 9 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital #2

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 29
b. COUNTY: Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 217 North Howard

3. NAME OF DECEASED (Type or Print)
a. (First): Nettie
b. (Middle): Mae
c. (Last): Stillinger

4. DATE OF DEATH: (Month) Oct. (Day) 27, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 21, 1893

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 0/

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Malta Bend, Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William E. Bauer
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Margaret Orr
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518609863T

17. INFORMANT'S OWN SIGNATURE: X C. R. Stillinger
ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1530

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinoma of Cecum — INTERVAL BETWEEN ONSET AND DEATH: 2

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: diabetes mellitus — ?

19a. DATE OF OPERATION: Sept 1967

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Feb 1, 1945, *to* 10-27, 1967, *that I last saw the deceased alive on* 10-27, 1967, *and that death occurred at* 10:00 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul North Dunn MD (Degree or title) 149

23b. ADDRESS: Moscow Idaho

23c. DATE SIGNED: 10-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 31, 1967

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Gardens

24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 11-3-67

REGISTRAR'S SIGNATURE: Cheryl Ann Williams

25. EMBALMER: Fred J. Nelson

LICENSE NO.: E-504

FIRM NAME: Short's Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 7 1967

State File No. 4579
Local Reg. No. 143
Reg. Dist. No. 200

Certificate of Death

RECEIVED
NOV 13 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 291 Latah 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. STATE OF STAY (in this place): 9 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 281
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Couer d'Alene
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Carl
b. (Middle): Freeman 329
c. (Last): Bechtol

4. DATE OF DEATH (Month) (Day) (Year): Oct 31 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: March 18, 1885
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country):
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-18-8415
17. INFORMANT'S OWN SIGNATURE: x Mary Lanphier — ADDRESS: Spokane, Wn.

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1967 *to* Oct. 31, 1967, *that I last saw the deceased alive on* Oct. 29, 1967, *and that death occurred at* 8:25 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Edward L Boas 788 MD (Degree or title)
23b. ADDRESS: Prof. Bldg Moscow
23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-6-1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery
24d. LOCATION (City, town, or county) (State): Couer d'Alene Idaho

DATE REC'D BY LOCAL REG.: 11-10-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 24 1996

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4580
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

OCT 23 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 300 Lemhi 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Salmon

c. LENGTH OF STAY (in this place) d.o.a.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Steele Memorial 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE 05 Calif. b. COUNTY 555 Los Angeles

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) South Gate

d. STREET ADDRESS (If rural, give location) 8914 Beaudine Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Marvin	Clifford	McCreary	Oct. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	March 20, 1918	49				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rubber worker--Firestone	06	Cherokee, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Garth W. McCreary	Iowa	Edna Parcel	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW 2 4	470-18-5582	Donald L McCreary	Lake Wood, Cal

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Skull fracture — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13	(COUNTY) 190	(STATE)
Accident	1 mi. W of Challis 12	near Challis	Custer	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Oct. 10, 1967 8:30P m.		Jeep turned over rolling on victim

22. *I hereby certify that I attended the deceased from* 10-10, 1967, *to* 10-10, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 10:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M Moore 369 1	Salmon, Idaho	10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Transportation & burial	10-16-67	Rolling Hills	SanPedro, California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct 25 '67	Viola E. Johnson	Delbert C. Jones	E369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4581
Local Reg. No. 690
Reg. Dist. No.

REC Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 30 1967

Bureau of Vital Sta.

1. PLACE OF DEATH

a. COUNTY: 300 Lemhi 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon

c. LENGTH OF STAY (in this place): d.o.a.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: 27 Montana

b. COUNTY: 555 Silver Bow

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Butte (4 years)

d. STREET ADDRESS (If rural, give location): (Cobalt, Idaho for 2 mos.)

3. NAME OF DECEASED (Type or Print)

a. (First): Clayton

b. (Middle): Marion

c. (Last): Furr, Jr.

4. DATE OF DEATH (Month) (Day) (Year): Oct. 19, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 16, 1938

9. AGE (In years last birthday): 29 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): miner 07

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cassity, W. Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clayton M. Furr, Sr. — BIRTHPLACE: W. Va.

14. MOTHER'S MAIDEN NAME: Rachael Holknighter — BIRTHPLACE: W. Va.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): 1956 - 1959 6

16. SOCIAL SECURITY NO.: 235-58-9380

17. INFORMANT'S OWN SIGNATURE: Betty Jean Furr — ADDRESS: Cobalt, Ida.

9192

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crush injury skull — INTERVAL BETWEEN ONSET AND DEATH: 20 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): mine accident

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Idaho Mining Co.

21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 300 (STATE): Cobalt Lemhi Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 10 19 67 6:30 AM

21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Rock fell on head -

22. *I hereby certify that I attended the deceased from* Wene *to* _____, *19*___, *that I last saw the deceased alive on* _____, *19*___, *and that death occurred at* 7A *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. L. Blackaday M.D. 045 (Degree or title)

23b. ADDRESS: Salmon, Ida

23c. DATE SIGNED: 10-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Transp. & Burial

24b. DATE: 10-21-67

24c. NAME OF CEMETERY OR CREMATORY: Richwood Cemetery

24d. LOCATION (City, town, or county) (State): Richwood, W. Virginia

DATE REC'D BY LOCAL REG.: Oct 26-67

REGISTRAR'S SIGNATURE: Viola E. Johnson

25. EMBALMER: Delbert C. Jones — LICENSE NO. E369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4582
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

RECEIVED NOV 6 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 300 Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 5 mis. West of Indianola
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ranger Station

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 03 Arizona
b. COUNTY 53
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 720 E. Holloway, Tucson (8 yrs.)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Willie	Lois	Kelley	Oct. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Dec. 17, 1918	48				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06		Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William C. Kelley	Texas	Nettie McDaniels	Oklahmma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
unknown	unknown	Taken over telephone	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Drowning — INTERVAL BETWEEN ONSET AND DEATH: none

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 300 (STATE)
Accident /	Highway 06	near Indianola Ranger Station, Lemhi,

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Oct. 29, 1967 7 P m.		Trapped in over turned pickup in Salmon River (Idaho

22. *I hereby certify that I attended the deceased from* none, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M Moore 369 MD	Salmon, Idaho	10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Transp.& Burial	10-31-67	Tucson Mem.Park Southlawn	Tucson, Pima, Arizona

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 2 29 67	Viola E. Johnson	Delbert C. Jones	E369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED.
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4583
Local Reg. No. 654
Reg. Dist. No. 430

BIRTH NO.

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Lincoln 320
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Shoshone
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5 miles So. Shoshone Hwy-93 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 070
b. COUNTY Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
d. STREET ADDRESS (If rural, give location) 415 E. Carbonate

3. NAME OF DECEASED (Type or Print) a. (First) Kenneth b. (Middle) L. c. (Last) Petersen
4. DATE OF DEATH (Month) (Day) (Year) Oct. 12, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH Aug. 11, 1948
9. AGE (In years last birthday) 19 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY High School
11. BIRTHPLACE (State or foreign country) Wendell, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Dale H. Petersen
BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Leona Tustanowsky
BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-56-9301
17. INFORMANT'S OWN SIGNATURE Dale H. Petersen
ADDRESS Hailey

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Neck — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hwy-93, 5 Miles South
21c. (CITY, TOWN, OR TOWNSHIP) Shoshone (COUNTY) Lincoln (STATE) Idaho
21d. TIME OF INJURY (Month) Oct (Day) 12 (Year) 67 (Hour) 2:30 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? One car auto accident

22. I hereby certify that I attended the deceased from Oct. 12, 19 67, to Oct. 12, 19 67, that I last saw the deceased alive on Oct. 12, 19 67, and that death occurred at 2:30 p.m., from the causes and on the date stated above.

23a. SIGNATURE Richard Coroner 583 (Degree or title)
23b. ADDRESS Box 68 Shoshone Idaho
23c. DATE SIGNED 10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 14, 67
24c. NAME OF CEMETERY OR CREMATORY Hailey Cemetery
24d. LOCATION (City, town, or county) (State) Hailey, Idaho

DATE REC'D BY LOCAL REG. 10-17-67
REGISTRAR'S SIGNATURE Francis M. Bergin
25. EMBALMER Francis M. Bergin
LICENSE NO. E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4584
Local Reg. No. 655
Reg. Dist. No. 430

Certificate of Death

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 320 Lincoln 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone
c. LENGTH OF STAY (In this place) 4½ yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wood River Convalescent Ctr.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 190
b. COUNTY Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mackay
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) VERDA
b. (Middle) 240 HARRIETT
c. (Last) LARTER

4. DATE OF DEATH (Month) (Day) (Year) October 28, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH Feb. 4, 1896
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic 01
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Mt. Pleasant, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry T. Larter — BIRTHPLACE Moroni, Utah
14. MOTHER'S MAIDEN NAME Christina Jensen — BIRTHPLACE Mt. Pleasant, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE X Cheris Larter — ADDRESS Mackay, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

442X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerotic Cardiovascular Renal Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Acute Hypertrophic Arthritis — 6 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-23, 1963, *to* 10-28, 1967, *that I last saw the deceased alive on* 10-26-, 1967, *and that death occurred at* 10:50A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 386
23b. ADDRESS Box 68 Shoshone Idaho
23c. DATE SIGNED 10-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-31-67
24c. NAME OF CEMETERY OR CREMATORY Mt. McCaleb Cemetery
24d. LOCATION (City, town, or county) (State) Mackay, Idaho

DATE REC'D BY LOCAL REG. 11-2-67
REGISTRAR'S SIGNATURE Francis M. Bergin
25. EMBALMER [signature]
LICENSE NO. E-457

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
SEP 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4585
Local Reg. No. 46
Reg. Dist. No. 630

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 33 Madison 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Green's Rest Home 228

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16 b. COUNTY Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 670 L Street

3. NAME OF DECEASED (Type or Print) a. (First) Rosie b. (Middle) Shepperd c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) August 5, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 26, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR Months: 0 Days: 9 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Rexburg, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Williams Shepperd — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Christine Nelson — BIRTHPLACE: Lehi, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. NONE
17. INFORMANT'S OWN SIGNATURE x Lisa Stewart — ADDRESS Idaho Falls, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-5, 1967, *to* 8-5, 1967, *that I last saw the deceased alive on* 8-5, 1967, *and that death occurred at* 5 34 m., *from the causes and on the date stated above.*

23a. SIGNATURE Lester A Petersen MD 413 (Degree or title)
23b. ADDRESS Rexburg Idaho
23c. DATE SIGNED 9-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem & Bur 3
24b. DATE 6 Sept 1967
24c. NAME OF CEMETERY OR CREMATORY Fielding Memorial Park
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. 9-21-67
REGISTRAR'S SIGNATURE Lona Flamm
25. EMBALMER Leo A Williams
LICENSE NO. E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4586
Local Reg. No. 47
Reg. Dist. No. 630

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY 330 Madison — NOV 1 1967 — 000
b. CITY OR TOWN Salem — (If outside corporate limits, write RURAL and give township) Bureau of Vital Statistics — STATEMENT OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rexburg Rt. 2 — 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE Idaho — b. COUNTY 330 Madison
c. CITY OR TOWN Salem — (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location) Rexburg Rt. 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CLARISSA	ESPLIN	LUKE	September 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	November 19, 1879	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 07		Orderville, Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Esplin	Scotland	Margaret Webster	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Lowell M. Luke	Rt #2 Rexburg Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — several years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July, 1960, *to* Sept 22, 1967, *that I last saw the deceased alive on* Sept 12, 1967, *and that death occurred at* 2:45 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lester J. Peterson	413 MD 1	Rexburg Idaho	9-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	9/25/67	Sugar City	Sugar City Madison Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
9-25-67	Lena Flamm	Brent Flamm	E347

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 23 1991

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4587
Local Reg. No. 49
Reg. Dist. No. 650

BIRTH NO.

1. PLACE OF DEATH — NOV 1 1967
a. COUNTY Madison 331 Bureau of Vital Statistics 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Madison Memorial Hospital 623

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 51 Wyoming
b. COUNTY 555 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Freedom
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) — a. (First) b. (Middle) c. (Last): Dorothy Lavina Hepworth Moser

4. DATE OF DEATH (Month) (Day) (Year): October 17, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: January 14, 1909
9. AGE (In years last birthday): 58
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country): Grover, Wyoming
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME — BIRTHPLACE: George Hepworth, Grover, Wyo.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Camera Thurman, Hyde Park, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: unknown
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Erwin H. Moser — Freedom, Wyoming

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 14 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 15, 1967, *to* Oct 17, 1967, *that I last saw the deceased alive on* Oct 17, 1967, *and that death occurred at* 11:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 409 (Degree or title)
23b. ADDRESS: Rexburg Ed. 60
23c. DATE SIGNED: 10-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 10/18/67
24c. NAME OF CEMETERY OR CREMATORY: Freedom Cemetery
24d. LOCATION (City, town, or county) (State): Freedom, Lincoln, Wyoming

DATE REC'D BY LOCAL REG.: 10-23-67
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: [signature]
LICENSE NO.: E347
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4588
Local Reg. No. 50
Reg. Dist. No. 630

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Madison 230 NOV 1 1967 000
b. CITY OR TOWN Rural Archer (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 330 b. COUNTY Madison
c. CITY OR TOWN Rural Archer (If outside corporate limits, write RURAL and give township)

d. FULL NAME OF HOSPITAL OR INSTITUTION Rt. 1 Thornton, Idaho 000 (If not in hospital or institution, give street address or location)
d. STREET ADDRESS Rt. 1 Thornton, Idaho (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) MATILDA c. (Last) ERICKSON PAYN

4. DATE OF DEATH (Month) (Day) (Year) October 18, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 30, 1880
9. AGE (In years last birthday) 87 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bjorke, Alvsborg, Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Erick Erickson Bodahult Trokorna, Sweden BIRTHPLACE
14. MOTHER'S MAIDEN NAME Christina Anderson Bodahult Trokorna, Sweden BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-64-2287
17. INFORMANT'S OWN SIGNATURE Mrs. Eldon Robison ADDRESS Rt. 1 Thornton, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Rheumatoid Arthritis Severe — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 1, 1966, *to* Oct. 18, 1967, *that I last saw the deceased alive on* Oct. 18, 1967, *and that death occurred at* 11:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Asael Tall, 522 (Degree or title) M.D.
23b. ADDRESS Rigby, Idaho
23c. DATE SIGNED 10-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/21/67
24c. NAME OF CEMETERY OR CREMATORY Sutton
24d. LOCATION (City, town, or county) (State) Archer Madison Idaho

DATE REC'D BY LOCAL REG. 10-21-67
REGISTRAR'S SIGNATURE Leona Flamm
25. EMBALMER
LICENSE NO. E347
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4589
Local Reg. No. 57
Reg. Dist. No. 690

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Madison 330 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sugar City (Rural)
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sugar City Rt. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 33
b. COUNTY Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sugar City
d. STREET ADDRESS (If rural, give location) Sugar City Rt.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JAMES	HENRY	RICKS	October 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Jan. 31, 1897	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rexburg, Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Ricks	Logan, Utah	Sarah Ellen Harris	Pleasant Grove, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-26-3118
17. INFORMANT'S OWN SIGNATURE Basil Smith ADDRESS Rexburg

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Natural
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home
21c. (CITY, TOWN, OR TOWNSHIP) Sugar City (COUNTY) Madison (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) None m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-26, 1967, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 2:15 p.m. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. Richardson	583 Coroner 4	Rexburg, Idaho	10-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/28/67	Rexburg Cemetery	Rexburg Madison Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-28-67	Leona Flamm	Burnell Flamm	E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4590
Local Reg. No. 70
Reg. Dist. No. 450

RECEIVED
OCT 16 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 340 Minidoka 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
LENGTH OF STAY IN (this place): 10yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): R.F.D. 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 340 Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
d. STREET ADDRESS (If rural, give location): R.F.D.

3. NAME OF DECEASED (Type or Print): a. (First) Jerry b. (Middle) Bruce c. (Last) Scott

4. DATE OF DEATH (Month) (Day) (Year): Oct. 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	never married	May 2, 1953	14				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
student 03	High School	Pocatello, Idaho	U.S.A.

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
Bernard E. Scott - Kearney, Neb.	Jeanne Nelson - Heyburn, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- - -	519-56-8349	Bernard E. Scott	Heyburn, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1967 Osteosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 14 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-17-67	Osteogenic Sarcoma Femur	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 5-24, 1966, *to* 10-4, 1967, *that I last saw the deceased alive on* 10-4, 1967 *and that death occurred at* 1030 *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[illegible] 283 (Degree or title)	Burley Idaho	10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-7-67	Riverside Cemetery	Heyburn, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-67	Mary Ellen Barlow	[illegible]	E 389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4591
Local Reg. No. 68
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka OCT 9 1967 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert Bureau of Vital Statistics
LENGTH OF STAY (in this place) 307 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 317 3rd street

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) 125
c. (Last) Hieb

4. DATE OF DEATH (Month) (Day) (Year) Oct 5 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years) Last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 2 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) U.P.Rail way Retired 10
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Hieb — BIRTHPLACE Russia
14. MOTHER'S MAIDEN NAME Christina Hieb — BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-30-2828
17. INFORMANT'S OWN SIGNATURE Lydia Hieb — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5702 Mesenteric thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) and Infarct of small bowel.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of liver

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-29, 1967, *to* 9-5, 1967, *that I last saw the deceased alive on* Oct 4, 1967, *and that death occurred at* 7:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 365 (Degree or title)
23b. ADDRESS Rupert Idah
23c. DATE SIGNED 9-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 9 1967
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) Rupert Idaho (State)

DATE REC'D BY LOCAL REG. 10-6-67
REGISTRAR'S SIGNATURE Mary Ellen Barlow
25. EMBALMER Robert O Walk
LICENSE NO. 6294
FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

NOV 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 6 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4592
Local Reg. No. 72
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Near Paul Idaho | LENGTH OF STAY (in this place) 1 week 307
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Heinze Labor Camp 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 05 California b. COUNTY Fresno 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinedale
d. STREET ADDRESS (If rural, give location) 246 Beechwood Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Frank		Romero	Oct 6 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years Last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Mexican	Married 3	June 22 1906	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Laborer 04		unknown	unknown

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Mike Romero	unknown	Patsy Ruiz	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	547 28 0483	Minidoka Co. Coroner - R. C. Walk - Rupert	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

525X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonitis, lobular, bilateral — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fibrosis, pulmonary — yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I* ~~attended~~ *the deceased from* Pre-formed autopsy Oct 6, 19 67, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burdell McCarley MD 1	Magic Valley Mem Hosp Twin Falls	10-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10-10-67		Fresno California

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-18-67	Mary Ellen Barker	Robert C Walk	E 294

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Walk Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 10 1988

MAY 05 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 20 1967 Bureau of Vital Statistics

State File No. 4593
Local Reg. No. 73
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 340 Minidoka 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
DURATION OF STAY (in this place) 1 day

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Paul 340 b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho
d. STREET ADDRESS (If rural, give location) 600 west 900 north

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 125 Minidoka Memorial Hospital

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Bessie	Ann	Spencer	10-10-67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Navaho Indian	Married 3	June 30 1936	31				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Thoreeu New Mexico	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wilson Mariano	Thoreeu New Mexico	Alice Ann Cadman--Twin Lake New Mex	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give year or dates of service)	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	not known	Minidoka County Coroner - R. C. Walk - Rupert

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage Contusion, Brain Massive — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fractures, Skull occipital & Temporal left — Hours
DUE TO (c) Blunt impact to Head.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Tuberculosis, old, fibrocaseous, inactive

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 340 (COUNTY) (STATE)
	600 West-Baseline Road - 13	Paul, Minidoka County, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
10-10-67 a.m.		Apparently hit from rear by unknown car or truck, left lying in road injured.

22. *I hereby certify that I attended the deceased from* Performed autopsy Oct 12, 1967, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Birdsall McCall MD	1111 Main Hwy Twin Falls	Oct 12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	10-14-1967	Indian Tribal Cemetery	Gallup New Mexico

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-18-67	Mary Ellen Hanson	Robert C Walk	E 294

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

AUG 18 2006

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician. This person was found lying in the road at 600 West and Baseline road apparently the victim of a hit and run driver, unknown. The sheriffs office took her to the Minidoka Memorial Hospital, unconscious, where she later died. Autopsy performed by Dr. Birdselle Carle, pathologist, Twin Falls, Idaho. Robert Walk, Coroner 12-27-67

Certificate of Death

STATE OF IDAHO

State File No. 4594
Local Reg. No. 76
Reg. Dist. No. 450

RECEIVED OCT 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write township) Rupert
Statement of STAY (in this place) two weeks 314
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital
d. STREET ADDRESS (If rural, give location) 430 North 625 East

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340
b. COUNTY Minidoka

3. NAME OF DECEASED (Type or Print)
a. (First) Robert
b. (Middle) 125
c. (Last) Pfnister

4. DATE OF DEATH (Month) (Day) (Year) October 11 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug 28 1905
9. AGE (In years last birthday) 62
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Bible Grove Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE George Pfnister--Salem Illinois
14. MOTHER'S MAIDEN NAME BIRTHPLACE Etha Carter Bible Grove Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-32-0687
17. INFORMANT'S OWN SIGNATURE Mrs Robt Pfnister ADDRESS Rupert Idah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

465X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH 2 wks.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1, 1967, *to* Oct. 11, 1967, *that I last saw the deceased alive on* Oct. 11, 1967, *and that death occurred at* 3:55 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE W. W. Crawford, M.D. 740 (Degree or title)
23b. ADDRESS Rupert, Idaho
23c. DATE SIGNED 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Sat Oct 14
24c. NAME OF CEMETERY OR CREMATORY 1967 Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 10-26-67
REGISTRAR'S SIGNATURE Mary Ellen Barbour
25. EMBALMER Robert E Walk
LICENSE NO. E 294
FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 01 1999

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 21 2000

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4595
Local Reg. No. 71
Reg. Dist. No. 450

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 340 Minidoka 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MINIDOKA MEMORIAL HOSPITAL 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): m R.F.D. # 3

3. NAME OF DECEASED (Type or Print)
a. (First): FLORENCE
b. (Middle): TILLSON
c. (Last): RING

4. DATE OF DEATH (Month) (Day) (Year): Oct. 11, 1967

5. SEX: Female m
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 29, 1888
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Livermore, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles E. Tillson — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Eliza Buell — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-54-0144
17. INFORMANT'S OWN SIGNATURE: Elizabeth R. Conover — ADDRESS: Rt#3 Buhl

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Metastatic Ca Breast — 2 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-1, 1967, *to* 10-11, 1967, *that I last saw the deceased alive on* 10-11, 1967, *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: T. A. Hunt 255 (Degree or title) MD
23b. ADDRESS: Rupert, Idaho
23c. DATE SIGNED: 10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/14/67
24c. NAME OF CEMETERY OR CREMATORY: Buhl
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 10-16-67
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: George Farmer — LICENSE NO.: E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4596
Local Reg. No. 74
Reg. Dist. No. 450

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
LENGTH OF STAY (in this place) 3 months

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340 b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital
d. STREET ADDRESS (If rural, give location) 200 North 350 West

3. NAME OF DECEASED (Type or Print) a. (First) Maryan b. (Middle) [illegible] c. (Last) Walters

4. DATE OF DEATH (Month) (Day) (Year) Oct 15 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Sept 29 1917

9. AGE (In years last birthday) 50 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Sugar City Colorado

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Chris Weber BIRTHPLACE Russia

14. MOTHER'S MAIDEN NAME Marie Schnieder BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 524-16-1700

17. INFORMANT'S OWN SIGNATURE x Alvin Walters ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastasis from carcinoma of
DUE TO (c) right breast

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/11, 1965, *to* Oct 15, 1967, *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at* 7:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE Q J Dalley (Degree or title) M D

23b. ADDRESS 702 G St Rupert Idaho

23c. DATE SIGNED 10/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct 19 1967

24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery

24d. LOCATION (City, town, or county) (State) Paul Idaho

DATE REC'D BY LOCAL REG. 10-19-67

REGISTRAR'S SIGNATURE Mary Ellen Larson

25. EMBALMER Robert Walk

LICENSE NO. E 294

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4597
Local Reg. No. 75
Reg. Dist. No. 450

Certificate of Death

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 160
b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Albion
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Rachel
b. (Middle) Viola
c. (Last) RUMSEY

4. DATE OF DEATH (Month) (Day) (Year) October 22, 1967

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH January 5, 1900
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Lexington, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Francis George Goodrow — BIRTHPLACE France
14. MOTHER'S MAIDEN NAME Sarah Bertwell — BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. 540-32-7415A
17. INFORMANT'S OWN SIGNATURE Lynn Otthman — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

150X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Esophagus — INTERVAL BETWEEN ONSET AND DEATH 3 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION Aug 1967
19b. MAJOR FINDINGS OF OPERATION resection of esophagus & plastic repair
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) ~~Jan~~ m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 16, 1967, *to* Oct 21, 1967, *that I last saw the deceased alive on* Oct 21, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE C. A. Moellmer M.D. 366 (Degree or title)
23b. ADDRESS Rupert, Idaho
23c. DATE SIGNED 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal to
24b. DATE Oct. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY Vale Cemetery
24d. LOCATION (City, town, or county) (State) Vale, Oregon

DATE REC'D BY LOCAL REG. 10-23-67
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER J. Robert C. Walk
LICENSE NO. E-294

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4598
Local Reg. No. 243
Reg. Dist. No. 220

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35 000
b. CITY OR TOWN: Lewiston
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Rural-4 mi. E. city limits 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 35
c. CITY OR TOWN: Lewiston
d. STREET ADDRESS (If rural, give location): 410 - 1st Ave.

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM (Rudolph) b. (Middle) ROBERT c. (Last) HILL

4. DATE OF DEATH: (Month) 30 Sept (Day) (Year) 1967

5. SEX: Male
6. COLOR OR RACE: Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): No Record 0
8. DATE OF BIRTH: 7 Feb. 1917
9. AGE (In years last birthday): 50 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Auto Washer 04
10b. KIND OF BUSINESS OR INDUSTRY: Ford Agency
11. BIRTHPLACE (State or foreign country): No Record
12. CITIZEN OF WHAT COUNTRY?: No Record

13. FATHER'S NAME: No Record — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME: No Record — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No Record
16. SOCIAL SECURITY NO.: 185 10 9489
17. INFORMANT'S OWN SIGNATURE: X Mena Hedrick — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Shock & Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Moments

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Head & Chest injuries
DUE TO (c): Auto Accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident /
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): State HiWay #12 06
21c. (CITY, TOWN, OR TOWNSHIP) 23 (COUNTY) 350 (STATE): Lewiston (rural) NezPerce Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 30Sept1967-6:30 PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Decedents auto crossed center line striking on-coming auto.Head-On.

22. *I hereby certify that I attended the deceased from* - - - 3 -, 19 -, *to* - - - - - -, 19 -, *that I last saw the deceased alive on* - - - - - -, 19 -, *and that death occurred at* 6:30PM m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wilbur A. Proctor — 383 (Degree or title): Co. Coroner 4
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 30 Sept 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 21 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-25-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-295

FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 3 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4599
Local Reg. No. 229
Reg. Dist. No. 220

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 731 Preston Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): LUCILLE
c. (Last): MERCER

4. DATE OF DEATH (Month) (Day) (Year): 2 October 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: 25 Dec. 1901
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Psychologist 08
10b. KIND OF BUSINESS OR INDUSTRY: Ida. Dept. of Health
11. BIRTHPLACE (State or foreign country): Harrisville, Ohio
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William H. Mercer — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Blanche Mills — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 271 12 3361
17. INFORMANT'S OWN SIGNATURE: Florence B. Barton — ADDRESS: Needham Hgts, Mass.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

500X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Undetermined.
ANTECEDENT CAUSES — Had weakness and dyspnea
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): since a flu-like illness 1 mo ago.
DUE TO (c): Acute bronchitis
II. OTHER SIGNIFICANT CONDITIONS — Cardiac enlargement
Conditions contributing to the death but not related to the disease or condition causing death.
severe kypho-scoliosis residual to polio at age 3.

INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-22, 1967, *to* 10-2, 1967, *that I last saw the deceased alive on* 10-2, 1967, *and that death occurred at* 7:40 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. E. Eastwood MD 152
23b. ADDRESS: Lewiston Idaho
23c. DATE SIGNED: 10/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 6 Oct. 1967
24c. NAME OF CEMETERY OR CREMATORY: Hargrave Funeral Home
24d. LOCATION (City, town, or county) (State): Adena, Jefferson Co., Ohio

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE: Lynnette Knott
25. EMBALMER: L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended October 25, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4600
Local Reg. No. 233
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston (Rural)
d. STREET ADDRESS (If rural, give location): 3427-4th St. D.

3. NAME OF DECEASED (Type or Print): a. (First) George b. (Middle) E. c. (Last) Heitman

4. DATE OF DEATH: (Month) Oct. (Day) 3, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 19, 1930

9. AGE (In years last birthday): 37
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver 27

10b. KIND OF BUSINESS OR INDUSTRY: Star Motor Freight

11. BIRTHPLACE (State or foreign country): Gifford, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Louis E. Heitman
BIRTHPLACE: Ill.

14. MOTHER'S MAIDEN NAME: Marie Brammer
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Nov 8,50-Sept 27

16. SOCIAL SECURITY NO.: 54,519-30-8710

17. INFORMANT'S OWN SIGNATURE: Josephine A. Heitman
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Ischemia due to

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) anomalous right coronary artery and atherosclerosis

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Vagotomy & Pyloroplasty

19a. DATE OF OPERATION: 2 Oct 67

19b. MAJOR FINDINGS OF OPERATION: Healed duodenal ulcer

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 14, 19 67, *to* 3 Oct., 19 67, *that I last saw the deceased alive on* 2 Oct., 19 67, *and that death occurred at* 5 Am., *from the causes and on the date stated above.*

23a. SIGNATURE: David W. Heusinkveld, M.D. 227 / (Degree or title)

23b. ADDRESS: 307 St. John's Way

23c. DATE SIGNED: 16 Oct. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Oct 6, 1967

24c. NAME OF CEMETERY OR CREMATORY: Good Hope Lutheran Cemetery

24d. LOCATION (City, town, or county) (State): Gifford, Idaho

DATE REC'D BY LOCAL REG.: 10-16-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: Andrew F. Vassar

LICENSE NO.: E315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH—BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of [redacted] or Death

RECEIVED
OCT 24 1967
Bureau of Vital Statistics

State of Idaho } ss.
County of Nez Perce }

Certificate No. 233

Date Filed Oct 16, 1967

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for George E. Heitman (Name on Original Certificate) who Died (Was Born or Died) on October 3, 1967 (Date of Event)
in Lewiston, Idaho. (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Birth	May 19, 1930	June 19, 1930
Death	Oct, 4 1967	Oct 3, 1967

Subscribed and sworn to before me this 23 day of Oct., 19 67

Notary Public, residing at Lewiston Idaho

My commission expires My Commission E... August 1, 1970

(Seal)

Signed Andrew A. Vassar Funeral Director
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

141-9th St, Lewiston, Idaho.
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of } ss.
County of }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this day of , 19

Notary Public, residing at

My commission expires
(Seal)

Signed
(Signature of Any Credible Person)

(Street Address, City, State)

FORM DPH - 51117

The attending physician signed under item 22 that date of death was

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 233
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1 MONTH
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston (Rural)
d. STREET ADDRESS (If rural, give location): 3427-4th St D.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	E.	Heitman	Oct 4 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	White	Married	May 19, 1930	37				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Truck driver	Star Motor Freight	Gifford, Idaho.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Louis E. Heitman	Ill	Marie Brammer	Idaho.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes Nov 8,50-Sept 27,54	519-30-8710	X Josephine A Heitman	Lewiston Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Ischemia due to

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Vagotomy + hydroplasty

INTERVAL BETWEEN ONSET AND DEATH: Unknown

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
2 Oct 67	Healed duodenal ulcer	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 14 Sept, 1967, *to* 30 Oct, 1967, *that I last saw the deceased alive on* 2 Oct, 1967, *and that death occurred at* 5 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David W. Herman Dodd MD	307 St Johns Way	16 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	Oct 6 1967	Good hope Lutheran Cemetery	Gifford, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-16-67	Lynette Knott	Andrew F. Vassar	E315

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4601
Local Reg. No. 237
Reg. Dist. No. 220

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 35 1 201
b. CITY OR TOWN Lewiston
LENGTH OF STAY (in this place) 1 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston Manor 318

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 18 Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	HARRIET	L.	NELSON	Oct.	7	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	white	widowed 2	Jan. 22, 1888	79		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Joplin, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William P. Carpenter	unknown	Mary unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-03-6463	Lorna Casteel	Orofino, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Cerebro-Vascular Accident	4 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Fracture Hip (Healing)	

33 1X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
8-22-67	Fracture Hip	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-21, 1967, *to* 10-7, 1967 *that I last saw the deceased alive on* 9-6, 1967, *and that death occurred at* 3 [illegible] m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Lewiston, Idaho	10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 10, 1967	Weseman	Orofino Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-20-67	Lynette Knott	[signature]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4602
Local Reg. No. 231
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 313
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 320-12th Street

3. NAME OF DECEASED (Type or Print)
a. (First) George
b. (Middle) E.
c. (Last) Hasson

4. DATE OF DEATH (Month) (Day) (Year) Oct. 8, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 4
8. DATE OF BIRTH Dec. 6, 1891
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) hotel clerk 25
10b. KIND OF BUSINESS OR INDUSTRY Hotel
11. BIRTHPLACE (State or foreign country) Iowa
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME no record — BIRTHPLACE
14. MOTHER'S MAIDEN NAME no record — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no record (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-18-0318A
17. INFORMANT'S OWN SIGNATURE Hospital Rec AFV — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) arteriosclerotic cardiac — INTERVAL BETWEEN ONSET AND DEATH 10 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Vascular Disease grade 2
DUE TO (c) Aortic Stenosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1958, *to* date 19__, *that I last saw the deceased alive on* 10/8, 1967 *and that death occurred at* 10:35 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Galen A. Rogers MD — 446 (Degree or title)
23b. ADDRESS GALEN A. ROGERS, M.D. 900 Seventh St. Clarkston, Washington
23c. DATE SIGNED 10/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Oct. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 10-10-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER V. Vassar
LICENSE NO. E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4603
Local Reg. No. 232
Reg. Dist. No. 220

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 / NezPerce 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bollinger Hotel 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 16
b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
d. STREET ADDRESS (If rural, give location) State Hospital North

3. NAME OF DECEASED (Type or Print)
a. (First) Ralph
b. (Middle) Thompson
c. (Last) Hinton

4. DATE OF DEATH (Month) Oct (Day) 9, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Aug 25 1913

9. AGE (In years last birthday) 52
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Psychologist, Ph.D.

10b. KIND OF BUSINESS OR INDUSTRY State Hospital

11. BIRTHPLACE (State or foreign country) Elgin, Ill.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME R Hinton,
BIRTHPLACE Ill

14. MOTHER'S MAIDEN NAME Alma Thompson
BIRTHPLACE Ill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes
(If yes, give war or dates of service) W.W. 11 4

16. SOCIAL SECURITY NO. 321-12-7960

17. INFORMANT'S OWN SIGNATURE Ralph Hinton III
ADDRESS 3702 Artesian, Riverside, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occ

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9, 1967, *to* 10-9, 1967, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 7:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE John E. Carssow MD (Degree or title)

23b. ADDRESS Carssow Bldg., Lewiston, Idaho

23c. DATE SIGNED 10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Oct, 12, 67

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) Quincy, Ill. (State)

DATE REC'D BY LOCAL REG. 10-10-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER Andrew F. Vassar
LICENSE NO. E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 1 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 16 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

DEC 1 1967

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

OCT 13 1969

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

AUG 21 1998

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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Certificate of Death

STATE OF IDAHO

State File No. 4604
Local Reg. No. 238
Reg. Dist. No. 220

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 350 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lenore
DURATION OF STAY (in this place): minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L-C Highway # 12 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater 180
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pierce
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Frank	J.	Fromelt	Oct.	9	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	Married 3	Dec. 27 1888	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logging Contractor
10b. KIND OF BUSINESS OR INDUSTRY: Timber
11. BIRTHPLACE (State or foreign country): Troutdale, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frank Fromelt	unknown	unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW I 3	518-36-4972	X Jane Fromelt	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) (None)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 1:30 p m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wilfred J. Ducker 583	Coroner	Lewiston Idaho	10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Entombment	Oct. 12, 1967	Crestview Mausoleum	Lewiston	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-20-67	Lynette Knott	Lyle A. Gilbertson	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 3 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4605
Local Reg. No. 244
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nez Perce 351 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 350 b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lapwai
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	BARDT	NMI	MOODY	13 October 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Indian	Widowed 2	26 Dec. 1910	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Stock & Grain	Ferdinand, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Moody	Idaho	Fanny Parsons	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW-2 4	no record	+Mrs Lucille Bardt	Lapwai, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis 490 X — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchopneumonia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES X NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/12/67 *19*___, *to* 10/13/67, *19*___, *that I last saw the deceased alive on* 10/13/67 *19*___ *and that death occurred at* 10:40 am, *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
O.V. Baumann 036 (Degree or title) M. D.	626 5th Ave. Lewiston, Ida	10/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	17 Oct 1967	Meadow Creek Cemetery(Indian)	Ferdinand, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-25-67	Lynette Knott	L.E.DeBaun Malcom'sBrower-WannMemo.Chapel	E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

NOV 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4606
Local Reg. No. 239
Reg. Dist. No. 220

RECEIVED NOV 1 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: NezPerce 350 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
c. LENGTH OF STAY (in this place): 23 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor 318

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: 48 Washington COUNTY: 535 NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Asotin
c. STREET ADDRESS (If rural, give location): none

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Angelo		Giardinelli	Oct. 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married 3	June 10, 1896	71		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe line patrolman 09	Water Power Co.	Italy	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Giardinelli	Italy	LaGracia, Dieccpio	Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	536-05-3936A	Carl L Cooper	Missoula

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism Sec to 331X

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral hemorrhage
DUE TO (c) Cerebral arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* Nov 1948 *to* Oct 1967, *that I last saw the deceased alive on* 10 14, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Doctor or title)	23b. ADDRESS	23c. DATE SIGNED
Neville E Keeble MD	1419 Regional St Clarkston Wash	10/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal 3	Oct. 17, 1967	Vineland Cemetery	Clarkston, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-24-67	Lynette Knott	J. Vassar	E297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

NOV 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 6 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4607
Local Reg. No. 235
Reg. Dist. No. 220

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 122 -5th Street

3. NAME OF DECEASED (Type or Print)
a. (First): MABEL
b. (Middle): A.
c. (Last): LYON

4. DATE OF DEATH (Month) (Day) (Year): October 14, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 9/22/1917
9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Gull Lake, Saskatchewan, Canada
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: Charles Bloom — BIRTHPLACE: Unk
14. MOTHER'S MAIDEN NAME: Bertha Rutter — BIRTHPLACE: Unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: --------
17. INFORMANT'S OWN SIGNATURE: Arnold Lyon — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

491X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchopneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 3 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chronic Asthmatic Bronchitis — 3-4 yrs.
Rheumatic heart disease (Mitral stenosis) — 30+ yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept., 1966, *to* Oct., 1967, *that I last saw the deceased alive on* Oct. 13, 1967, *and that death occurred at* 6:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B R Stein 496 MD 1
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 17 Oct. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial 3
24b. DATE: 16 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 10-20-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Robert Larrabee — LICENSE NO.: [illegible]

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: MERCHANT FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: NOV 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4608
Local Reg. No. 240
Reg. Dist. No. 220

BIRTH NO. 67-10035

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 235
b. COUNTY Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kamiah
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) Stanley b. (Middle) Lee c. (Last) Kornoely

4. DATE OF DEATH: (Month) Oct. (Day) 14 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify):

8. DATE OF BIRTH: Oct. 13 1967

9. AGE (In years last birthday): 0 If under 1 year: Months 0 Days 1 If under 24 hrs.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Grangeville, Idaho.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lester Kornoely BIRTHPLACE: Kamiah, Idaho.

14. MOTHER'S MAIDEN NAME: Verna Payton BIRTHPLACE: Seattle, Wn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Lester W Kornoely ADDRESS: Kamiah Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyaline Membrane Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 13, 1967, *to* Oct 14, 1967, *that I last saw the deceased alive on* Oct 14, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 325 (Degree or title) M.D.

23b. ADDRESS: LEWISTON, IDAHO

23c. DATE SIGNED: 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 17, 1967

24c. NAME OF CEMETERY ~~OR CREMATORY~~: Pine Grove

24d. LOCATION (City, town, or county) (State): Kooskia Idaho

DATE REC'D BY LOCAL REG.: 10-24-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: Robert R Hansen LICENSE NO.: E433.

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4609
Local Reg. No. 236
Reg. Dist. No. 220

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
STATE OF (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Lewis 338
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Craigmont
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LEROY	PETER	LENZ	15 October 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	22 February 1902	65		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Stock & Grain	Craigmont (Ilo), Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elmer Lenz	Springfield, Ill.	Carrie Lenz	Iowa City, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 42 2453	Mrs Olivia Lenz	Craigmont, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Organic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Virus infection

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 10-15-67 *19*____, *to* _____, *19*____, *that I last saw the deceased alive on* None, *19*____, *and that death occurred at* 11:20 AM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen M. Cochran 649 MD	Lewiston Idaho	10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	18 Oct 1967	Lewis-Clark Memo. Gardens	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-20-67	Lynette Knott	Malcom's Brower-Wann Memo. Chapel	E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 10 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-9202
BIRTH NO.

Certificate of Death

RECEIVED STATE OF IDAHO

NOV 1 1967

Bureau of Vital Statistics

State File No. 4610
Local Reg. No. 234
Reg. Dist. No. 220

1. PLACE OF DEATH

a. COUNTY 35 NezPerce 310

b. CITY OR TOWN Lewiston

c. LENGTH OF STAY (in this place) 10 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 188

b. COUNTY Clearwater

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elk River

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)

a. (First) JULIE

b. (Middle) ANN

c. (Last) ENGER

4. DATE OF DEATH (Month) (Day) (Year) 15 October 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH 30 August 1967

9. AGE (In years last birthday) - - - - | IF UNDER 1 YEAR Months 1 Days 15 | IF UNDER 24 HRS. Hours - - Min. - -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Lewiston, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Enger — **BIRTHPLACE** Spokane, Wn

14. MOTHER'S MAIDEN NAME Carol Zimmerman — **BIRTHPLACE** Kendrick, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Charles A. Enger Jr. — **ADDRESS** Elk River, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7640

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Legund stresin — INTERVAL BETWEEN ONSET AND DEATH 6 wks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Pseudomembranous Gejunitis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Legund stresin

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* 15 Oct, 19 67, *that I last saw the deceased alive on* 15 Oct, 19 67, *and that death occurred at* 9:35 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE 227 (Degree or title) David W. Alexander MD

23b. ADDRESS 307 St John's Way

23c. DATE SIGNED 16 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 17 Oct 1967

24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery

24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 10-19-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER W. E. Black — Malcom's Brower-Wann Memo. Chapel — **LICENSE NO.** E-426

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4611
Local Reg. No. 249
Reg. Dist. No. 220

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY NezPerce 351 102
b. CITY OR TOWN Lewiston (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place) 2 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Whitebird
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) MATTIE b. (Middle) C. c. (Last) WYATT

4. DATE OF DEATH (Month) (Day) (Year): October, 17, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: April 11, 1880

9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Grangeville, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Jacob Crooks — BIRTHPLACE: Independence Mo.

14. MOTHER'S MAIDEN NAME: Victoria Chamberlain — BIRTHPLACE: Boone County, Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 54 6852

17. INFORMANT'S OWN SIGNATURE: Margaret V. Rose — ADDRESS: Lewiston Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Senile Dementia

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 1967, 19__, *to* Oct, 1967, *that I last saw the deceased alive on* Oct 16 1967, *and that death occurred at* 2:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. D. Glover (Degree or title) MD — **23b. ADDRESS**: Lewiston, Idaho — **23c. DATE SIGNED**: 10-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Oct. 21, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Whitebird — **24d. LOCATION** (City, town, or county) (State): Whitebird, Idaho

DATE REC'D BY LOCAL REG.: 11-1-67 — REGISTRAR'S SIGNATURE: Lynette Knott — **25. EMBALMER**: Robert Hansen — LICENSE NO.: 272

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Robertson-Hansen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4612
Local Reg. No. 241
Reg. Dist. No. 220

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 305
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 520 Aireway Drive

3. NAME OF DECEASED (Type or Print)
a. (First): CLYDE
b. (Middle): HENRY
c. (Last): PRYOR

4. DATE OF DEATH (Month) (Day) (Year): 19 October 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 5 Dec. 1907
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Security Police 17
10b. KIND OF BUSINESS OR INDUSTRY: Saw & Lumber Mill
11. BIRTHPLACE (State or foreign country): Alton, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert L. Pryor
BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Idela Pearl Amonett
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW-2 (If yes, give war or dates of service): 9
16. SOCIAL SECURITY NO.: 526 09 4071
17. INFORMANT'S OWN SIGNATURE: Mrs Ethel M Pryor
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Coronary Sclerosis — Yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1961, *to* Oct 19, 1967, *that I last saw the deceased alive on* Oct 19, 1967, *and that death occurred at* 11:40PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 013 (Degree or title) 1
23b. ADDRESS: 307 JJ Johnson Way
23c. DATE SIGNED: Oct 23-1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 23 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY: Weippe Cemetery
24d. LOCATION (City, town, or county) (State): Weippe, Clearwater Co., Idaho

DATE REC'D BY LOCAL REG.: 10-24-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L. E. DeBaun
LICENSE NO.: E-295
Malcom's Brower-Wann Memoirla Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4613
Local Reg. No. 242
Reg. Dist. No. 220

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 350
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lapwai
d. STREET ADDRESS (If rural, give location): P.O.Box - 79

3. NAME OF DECEASED (Type or Print)
a. (First): IRENE
b. (Middle): WILKINSON
c. (Last): ALLEN

4. DATE OF DEATH (Month) (Day) (Year): 19 October 1967

5. SEX: Female
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 22 Oct. 1900
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Spalding, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Amos Wilkinson — BIRTHPLACE: Washington
14. MOTHER'S MAIDEN NAME: No Record — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No Record
17. INFORMANT'S OWN SIGNATURE: + Delphine E Rose — ADDRESS: SanDiego, Cal.

18. CAUSE OF DEATH 7220
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: one wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gastroenteritis. — two wks
DUE TO (c) Rheumatoid arthritis — many yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 8:54 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C S Pughish MD 160 1
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 24 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY: Spalding Memo. Cemetery
24d. LOCATION (City, town, or county) (State): Spalding, Idaho

DATE REC'D BY LOCAL REG.: 10-25-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L. E. DeBaun — Malcom's Brower-Wann Memo. Chapel
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4614
Local Reg. No. 247
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 6 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (In this place) 206 6 MOS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 351 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) #10, 631 Preston Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPH
b. (Middle) 312 LEE
c. (Last) BROWN

4. DATE OF DEATH (Month) (Day) (Year) 22 October 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 3 Sept 1893
9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millworker 14
10b. KIND OF BUSINESS OR INDUSTRY Lumbering
11. BIRTHPLACE (State or foreign country) Southwick, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Orlando Brown — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Ida Tolstrip — BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 05 4442-A
17. INFORMANT'S OWN SIGNATURE Mrs Mildred L. Brown — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

451X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rupture of Aneurism of Abdominal Aorta — INTERVAL BETWEEN ONSET AND DEATH 8 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aneurism of abdominal Aorta — 3 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1965, *to* Oct 22, 1967, *that I last saw the deceased alive on* Oct 22, 1967, *and that death occurred at* 1:00PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Jack E Baldwin MD 022 (Degree or title)
23b. ADDRESS 1522 [illegible]
23c. DATE SIGNED 8/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 25 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 10-31-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 10 [redacted]

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
NOV 1 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4615
Local Reg. No. 246
Reg. Dist. No. 220
BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 310
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (In this place) 10days
d. FULL NAME OF HOSPITAL OR INSTITUTION St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1917-3rd Ave North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Joseph		Johnson		Oct	22,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	June 6, 1889	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Painter 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lockhaven, Penn
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Johnson	no record	Nancy Crotzer	No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 370-16-9931 A
17. INFORMANT'S OWN SIGNATURE Hospital Records ADDRESS C.F. Vassar

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	4281 Coronary occlusion	15 min.
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Carcinoma bladder	

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/16, 1964, *to* 10/22, 1967, *that I last saw the deceased alive on* 10/22, 1967, *and that death occurred at* 9:50 m., *from the causes and on the date stated above.*

23a. SIGNATURE R. J. Stuck, M.D. (Degree or title)
23b. ADDRESS 307 St Johns Way Lewiston
23c. DATE SIGNED 10/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10-26-67
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho.

DATE REC'D BY LOCAL REG. 10-26-67
REGISTRAR'S SIGNATURE Lynette K Knott
25. EMBALMER Andrew F. Vassar
LICENSE NO. E315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4616
Local Reg. No. 245
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 308
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 728-18th Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry	L	Reno	Oct. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Aug. 10, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
builder 11	self	Chester, Illinois	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Reno	no record	Ida Kennedy	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-01-1668A	Eugene L Reno	Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Sclerosis — 4 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March, 1959, *to* Oct 23, 1967, *that I last saw the deceased alive on* Oct 23, 1967, *and that death occurred at* 7 10 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John [illegible] MD	307 St Joseph Way	10/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct. 26, 1967	Normal Hill cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-25-67	Lynette Knott	V. Vasser	E297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

NOV 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 16 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended November 28, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4617
Local Reg. No. 248
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1815 - 16th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lorenzo	Randolph	DeLane	October 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	4 May 1905	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher 12	Education	Wardner, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John E. DeLane	Penna.	Helena J. Pauls	Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-16-2903	John M. DeLane, Lewiston, Idaho	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4638

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Massive Pulmonary Infarct	10 d
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Pulmonary Embolism	10 D
DUE TO (c)	Thrombophlebitis R Leg	12 D
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes Mellitus Congestive Heart Failure	Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
9-1967	Chronic Prostatism	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-10, 19 67, *to* 10-26, 19 67, *that I last saw the deceased alive on* 10-25, 19 67, *and that death occurred at* 10 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. G. Johnson, M.D. 781		Lewiston, Idaho	10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	30 Oct 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-31-67	Lynette Knott	W. E. Black	E-426

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

State of IDAHO
County of NEZ PERCE } ss.

Certificate No. Local Reg. 248

Date Filed 6 Nov 1967

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Lorenzo Randolph DeLane (Name on Original Certificate) who Died (Was Born or Died) on 26 Oct 1967 (Date of Event)
in Lewiston, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by Typographical Error & prepared on * * * * * * * * * (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Age	60	62

Subscribed and sworn to before me this 24th day of November, 1967

W. E. Black

Notary Public, residing at Lewiston, NezPerce Co., Ida.

My commission expires My Commission Expires 3-6-68

(Seal)

Signed K. H. Malcom K. H. Malcom Funeral Director
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of IDAHO
County of NEZ PERCE } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 24th day of November, 1967

W. E. Black

Notary Public, residing at W. E. Black, Notary Public Lewiston, NezPerce Co., Ida.

My commission expires My Commission Expires 3-6-68

(Seal)

Signed L. E. DeBaun L. E. DeBaun
(Signature of Any Credible Person)

P. O. Box 630, Lewiston, Idaho
(Street Address, City, State)

FORM DH 60-155

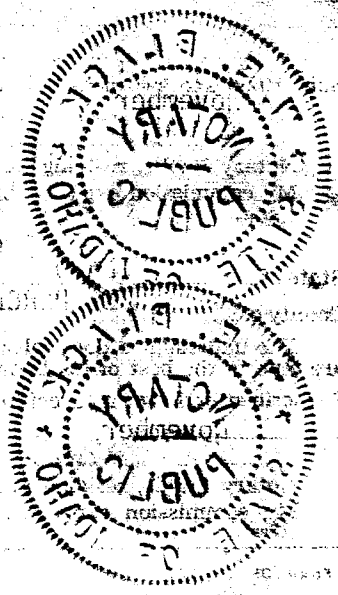
NOTARY
PUBLIC
IDAHO

State File No. 4617
Local Reg. No. 248
Reg. Dist. No. 220

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1815 - 16th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): LORENZO
b. (Middle): RANDOLPH
c. (Last): DeLANE

4. DATE OF DEATH (Month) (Day) (Year): 26 October 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: 4 May 1905
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Steacher
10b. KIND OF BUSINESS OR INDUSTRY: Education
11. BIRTHPLACE (State or foreign country): Wardner, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John E. DeLane — BIRTHPLACE: Penna.
14. MOTHER'S MAIDEN NAME: Helena J. Pauls — BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 16 2903
17. INFORMANT'S OWN SIGNATURE: John E. DeLane — ADDRESS: Lewiston Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Massive Pulmonary Infarct	10d.
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Pulmonary Embolism	10d -
DUE TO (c)	Thrombophlebitis R Leg	12d -
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes Mellitus Congestive Heart Failure	years

19a. DATE OF OPERATION: 9-1967
19b. MAJOR FINDINGS OF OPERATION: Chronic Prostatism
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-10, 1967, *to* 10-26, 1967, *that I last saw the deceased alive on* 10-25, 1967, *and that death occurred at* 10 A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD
23b. ADDRESS: Lewiston Idaho
23c. DATE SIGNED: 10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 30 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 10-31-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: W. E. Black — Maldom's Brower-Wann Memorial Chapel
LICENSE NO.: E-426

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4618
Local Reg. No. 251
Reg. Dist. No. 220

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY NexPerce 351 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
LENGTH OF STAY (in this place) 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555 Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clarkston
d. STREET ADDRESS (If rural, give location) 820 Riverview

3. NAME OF DECEASED (Type or Print)
a. (First) Dale
b. (Middle) Robert
c. (Last) Taylor

4. DATE OF DEATH (Month) (Day) (Year) October 28, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH March 12, 1949
9. AGE (In years last birthday) 18 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Kellogg, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Roy B. Taylor — BIRTHPLACE Loves Valley, Oak.
14. MOTHER'S MAIDEN NAME Sheilah I. Meagher — BIRTHPLACE Victoria, Australia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Roy B Taylor — ADDRESS Clarkston, Wn

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Head injury - probable skull fracture — INTERVAL BETWEEN ONSET AND DEATH 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) 23 (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 30 AM Oct 28, 19 67, *to* 3 04 AM Same date, 19___, *that I last saw the deceased alive on* 3 04 AM 10/28, 1967, *and that death occurred at* 3 04 A m., *from the causes and on the date stated above.*

23a. SIGNATURE Richard D Thorson MD 787 (Degree or title) 1
23b. ADDRESS 307 St Johns Way Lewiston Idaho
23c. DATE SIGNED Nov. 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Burial 5
24b. DATE Oct. 30, 67
24c. NAME OF CEMETERY OR CREMATORY Vineland Cemetery
24d. LOCATION (City, town, or county) Clarkston (State) Washington

DATE REC'D BY LOCAL REG. 11-1-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER W. C. Merchant
LICENSE NO. FD5

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Merchant Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Thomson

JAN 17 1968

MAR 8 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4619
Local Reg. No. 250
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 6 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 — 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: 555 Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 1100 11th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Margaret
b. (Middle): Helen
c. (Last): Kenyon

4. DATE OF DEATH (Month) (Day) (Year): October 28, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 5, 1914
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Eureka, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry Anderson — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Georgianna Swisher — BIRTHPLACE:
Georgianna S.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-46-3723
17. INFORMANT'S OWN SIGNATURE — ADDRESS:

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolus - 2 days before death — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial infarct.-4 days before death
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on* 10-28, 19 67, *and that death occurred at* 3 p.m. *m., from the causes and on the date stated above.*

23a. SIGNATURE 502 (Degree or title): DeStipe M.D. 1
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 10-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial
24b. DATE: 3 Oct. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetry
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 11-1-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: W.C. Merchant — LICENSE NO.: F.D. 5

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Merchant Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4620
Local Reg. No. 253
Reg. Dist. No. 220

BIRTH NO.

RECEIVED NOV 6 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 350 Nez Perce 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION 640 Preston 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 350 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
d. STREET ADDRESS (If rural, give location) 640 Preston

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	William	Clyde	Brown

4. DATE OF DEATH: (Month) Oct. (Day) 30, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married 3	May 3, 1894	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
real estate 24	real estate	Kansas City, Kansas	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edwin J. Brown	Illinois	Lelia McClellan	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
WW I	3	543-08-9274	Dinks Brown	Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Disease — Interval between onset and death: Seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 30-67, 19__ *to* Oct 30, 1967 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 10:45 m. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	021	Lewiston, Idaho	3 Nov. 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	Nov. 3, 1967	Hazen & Jaeger Crematory	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-3-67	Lynette Knott	V. Vassar	E. 297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4621
Local Reg. No. 252
Reg. Dist. No. 220

Certificate of Death

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 NezPerce 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 351 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1003-9th Ave

3. NAME OF DECEASED (Type or Print)
a. (First) Lois
b. (Middle)
c. (Last) Grogg

4. DATE OF DEATH (Month) (Day) (Year) Oct 30, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan 15, 1926
9. AGE (In years last birthday) 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Winchester, Idaho.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME John J. Fox — BIRTHPLACE Bartlesville, Neb.
14. MOTHER'S MAIDEN NAME Ivy Judd — BIRTHPLACE Utah.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-22-5805
17. INFORMANT'S OWN SIGNATURE X Gerold Grogg — ADDRESS Lewiston

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1992

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) generalized Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 30, 1967, *to* only, 19__, *that I last saw the deceased alive on* Oct. 30, 1967, *and that death occurred at* 1:20 p *m., from the causes and on the date stated above.*

23a. SIGNATURE John F. Barnes 028 (Degree or title) M.D.
23b. ADDRESS 347 St. John's Way, Lewiston, Ida.
23c. DATE SIGNED 10/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memorial Gardens
24d. LOCATION (City, town, or county) Lewiston, Idaho. (State)

DATE REC'D BY LOCAL REG. 11-2-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar
LICENSE NO. E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 06 2009

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
OCT 25 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4622
Local Reg. No. 21
Reg. Dist. No. 530

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 360 Oneida
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad
LENGTH OF STAY (in this place) 76 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 402 Bannock St. 176 550

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 360 Oneida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad
d. STREET ADDRESS (If rural, give location) 402 Bannock St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HARVEY	LUSK	JONES	September 21, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	married 3	Aug. 3, 1891	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	agriculture	Malad, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard Evans Jones	Brigham City, Utah	Louisa Lusk	Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no XXXXX	519-18-4006	Richard E Jones	Ogden, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 1960, *to* _____, 1965, *that I last saw the deceased alive on* Sept 19, 1967, *and that death occurred at* 8:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
315 M.D.		Malad, Idaho	Sept. 21, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Sept. 23, 1967	Malad City Cemetery	Malad, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 10-1967	Ruth L. Sweeten	Robert L. Benson	E-351

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: BENSON FUNERAL HOME

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4623
Local Reg. No. 20
Reg. Dist. No. 530

BIRTH NO.

OCT 25 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Oneida 360
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Oneida County Hospital 302

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Oneida 360
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City
d. STREET ADDRESS (If rural, give location): 227 Samaria Lane

3. NAME OF DECEASED (Type or Print): a. (First) BOYD; b. (Middle) STUART; c. (Last) MILLS

4. DATE OF DEATH: (Month) Oct. (Day) 11 (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Sept. 11, 1944

9. AGE (In years last birthday): 23
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --
10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Malad City, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: PAUL HENRY MILLS
BIRTHPLACE: Malad, Idaho

14. MOTHER'S MAIDEN NAME: MERLE STUART
BIRTHPLACE: MALAD, IDAHO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service): *

16. SOCIAL SECURITY NO.: **

17. INFORMANT'S OWN SIGNATURE: Paul H. Mills
ADDRESS: Malad, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 7441

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) muscular dystrophy — 19 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19__ *to* Oct 11, 1967, *that I last saw the deceased alive on* Oct. 11, 1967, *and that death occurred at* 1:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): M.D.
23b. ADDRESS: Malad City, Idaho
23c. DATE SIGNED: Oct. 13, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Malad City Cemetery
24d. LOCATION (City, town, or county) (State): Malad City, Oneida, Idaho

DATE REC'D BY LOCAL REG.: Oct. 13, 1967
REGISTRAR'S SIGNATURE: Ruth G. Sweeten
25. EMBALMER: Radford G. Benson
LICENSE NO.: E-351

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4624
Local Reg. No. 392
Reg. Dist. No.

BIRTH NO.

RECEIVED OCT 23 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Owyhee 370 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, Rt. # 1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Owyhee 370
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Goldie	Beatrice	Cook	Oct. 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	June 29, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 81
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Natal, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Manley Grant Lane — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Cleopatra Derona Ray — BIRTHPLACE: North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 519-40-5812B
17. INFORMANT'S OWN SIGNATURE + Clarence D. Cook — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration — INTERVAL BETWEEN ONSET AND DEATH: 1 YEAR

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Peritonsillar Abscess
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Exogenous Obesity,

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/9, 1967, *to* 10/13, 1967, *that I last saw the deceased alive on* 10/13, 1967, *and that death occurred at* 1:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald C. Bauman	034 MD 1	Caldwell Idaho	10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 16, 1967	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 21, 67	Andrew Warfield	Bennett E Spence	E-395

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4625
Local Reg. No. 392
Reg. Dist. No.

Certificate of Death

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 370 Owyhee 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Homedale Nursing Home 305

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wilder
d. STREET ADDRESS (If rural, give location): Rt. # 1

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Frederick
c. (Last): Miller

4. DATE OF DEATH (Month) (Day) (Year): Oct. 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 10, 1874
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Parkersburg, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frederick Miller — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Charlotte Snyder — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-54-3293J
17. INFORMANT'S OWN SIGNATURE: Della M Rockwood — ADDRESS: Wilder

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 1960 *to* Oct 28, 1967, *that I last saw the deceased alive on* Oct 24, 1967 *and that death occurred at* 5 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 570 MD
23b. ADDRESS: Caldwell Ida
23c. DATE SIGNED: 11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY: Fargo Cemetery
24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: Nov. 3, 1967
REGISTRAR'S SIGNATURE: Andrew Warfield
25. EMBALMER: Kenneth E. Spence
LICENSE NO.: E-395

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 16 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4626
Local Reg. No. 54
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 50 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rt 1 Box 6 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) Rt 1 Box 6

3. NAME OF DECEASED (Type or Print) a. (First) Filona b. (Middle) Belle c. (Last) Brooks

4. DATE OF DEATH (Month) Oct (Day) 11 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 10/28/94

9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home Maker

10b. KIND OF BUSINESS OR INDUSTRY Owne Home

11. BIRTHPLACE (State or foreign country) Caldwell Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME William Beeson — BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Martha Parsons — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-36-0504B

17. INFORMANT'S OWN SIGNATURE Melvin Brooks — ADDRESS Malin, Ore.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Scleratic Heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION** | **20. AUTOPSY?** YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) | **21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | **21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | **21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I* [illegible] Investigted and Oct 11, 19 67 [illegible] *and that death occurred at* 9:30a m., *from the causes and on the date stated above.*

23a. SIGNATURE Hardy H Larkson 583 (Degree or title) County Coronor — **23b. ADDRESS** 112½ N 8th Payette, Ida. — **23c. DATE SIGNED** 10/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** 10/14/67 — **24c. NAME OF CEMETERY OR CREMATORY** Riverside — **24d. LOCATION** (City, town, or county) (State) Payette, Idaho

DATE REC'D BY LOCAL REG. 10/13/67 — REGISTRAR'S SIGNATURE Roberta E Shaffer

25. EMBALMER Donald F. Brown — LICENSE NO. E-408

FIRM NAME: Payette Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4627
Local Reg. No. 55
Reg. Dist. No. 330

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 310 Payette 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
LENGTH OF STAY (in this place) 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 388 b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 410 S. 11th

3. NAME OF DECEASED (Type or Print) a. (First) Richard b. (Middle) 243 Clayton c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) October 21, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 8, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR Months — Days — IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service) – –
16. SOCIAL SECURITY NO. 429-26-4870
17. INFORMANT'S OWN SIGNATURE Keith M. Jones ADDRESS Idaho Public Assistant Records-Payette

18. CAUSE OF DEATH 332X
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — 1 year.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 1, 1966, *to* Oct. 21, 1967, *that I last saw the deceased alive on* Oct. 15, 1967, *and that death occurred at* 6:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE E. E. Arnold (Degree or title) M.D.
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY: Riverside
24d. LOCATION (City, town, or county) (State): Payette Idaho

DATE REC'D BY LOCAL REG.: 11-2-67
REGISTRAR'S SIGNATURE: Roberta E. Shaffer
25. EMBALMER: Keith M. Jones
LICENSE NO.: E-517
FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: FEB 7 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4628
Local Reg. No. 36
Reg. Dist. No. 330

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Payette 380
b. CITY OR TOWN: Fruitland
LENGTH OF STAY (in this place): Hrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ½ Mile M. Hwy 30 Carnefix Corner

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 38 Oregon
b. COUNTY: 555 Malheur
c. CITY OR TOWN: Ontario
d. STREET ADDRESS (If rural, give location): 408 S.E. 6th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Linda	G.	Terrell	Oct 30 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Mexican	Married 3	Aug 29 1939	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife 01	At Home	Montana	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Pete Garcia	Texas	Dominga Garcia	Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		516-44-5523	Jesse G Terrell	408 SE 6th

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Broken Neck	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Skull Fracture	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident /	Hwy 30 N. Fruitland	Fruitland	Payette	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
Oct. 30 1967 9P.M.		Car-Pedestrain Accident

22. *I hereby certify that I attended the deceased from* Invesaget Oct 30, *19*67, *that I last saw the deceased alive on* [illegible] *and that death occurred at* 9:15p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hardy Harkan	583 Cornor 4	112½ N. 8th Payette Ida	11/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	11/3/67	St John's	Ontario Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-2-67	Roberta E Shaffer	Donald F. Brown	E-408

FIRM NAME: Ontario Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 4 1989

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4629
Local Reg. No. 17
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Power
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 18 miles N. E. American Falls, near Snake River

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Nevada
b. COUNTY: Washoe
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Reno
d. STREET ADDRESS (If rural, give location): 750 Moana Lane

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	JOHN		ROGERS	Oct.	7,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 2, 1900	67	4	5		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired. Building & Finance		Modesto, Calif.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Roe Rogers	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1 3	519-22-4817	Loreta B. Rogers	Reno, Nevada

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Exertion
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* [illegible] *and saw the deceased alive last on* 10-7, 19 67, *and that death occurred at* 7:20a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bud Kelly	Coroner	American Falls, Idaho	10-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	10-9-67	Aultorest Memorial Crematory	Ogden, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-67	Callie Hatfield	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 24 2004

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 17 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4630
Local Reg. No. 15
Reg. Dist. No. 500-602

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power 390 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lincoln Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location) 409 Gifford

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARGARET	ANN	WORKMAN	Oct. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never married	June 17, 1949	18	3	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	School	Pocatello, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George A. Workman	Idaho American Falls,	Fern Miller, Am. Falls,	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			George A. Workman	Am. Falls, Ida.

18. CAUSE OF DEATH 9214

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Skull Fracture, rt. temple — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Motor Cycle accident.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 390 (STATE)
Accident	Street 04	American Falls Power Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Oct. 7, 1967 11:30 a. m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Motor Cycle accident

22. *I hereby certify that I attended the deceased from* [illegible] *last saw the deceased alive on* 10-7, 19 67, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bud Kelly	583 Coroner 4	American Falls, Idaho	10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-11-67	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-67	Colleen Hatfield	H. L. Davis	E-253

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4631
Local Reg. No. 16
Reg. Dist. No. 500-602

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Power 390 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lincoln Street 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CATHERINE	GRACE	GARRISON	Oct. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Never Married	May 8, 1951	16	4	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	School	Wendell, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Donal E. Garrison	Wendell, Idaho	Betty Anne Hunt	Pocatello, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-62-7664	Donal Garrison	Am. Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8214

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Internal Hemorrhage, abdominal area. — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Motor Cycle accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	13 (COUNTY)	390 (STATE)
Accident 1	Street 04	American Falls	Power	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Oct. 7, 1967, 11:30 a.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Motor Cycle Accident

22. *I hereby certify that I [redacted] last saw the deceased alive on* Oct. 7, 1967, *and that death occurred at* 11:30 Am., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bud Kelly	583 Coroner 4	American Falls, Idaho	10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	10-11-67	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-13-67	Callene Hatfield	H. L. Davis	E-253

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4632
Local Reg. No. 19
Reg. Dist. No. 500-602

RECEIVED
OCT 17 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power 390 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place) 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JOE
b. (Middle) R.
c. (Last) HAVLICAK

4. DATE OF DEATH (Month) (Day) (Year) Oct. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: Mar. 14, 1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months 6, Days 26 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Jackson, Minnesota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas H. Havlicak — BIRTHPLACE: Czechoslovakia
14. MOTHER'S MAIDEN NAME: Sophia Nepresh — BIRTHPLACE: Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-40-4328A
17. INFORMANT'S OWN SIGNATURE: Robert Havlicak — ADDRESS: Am. Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5400

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible]

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) [illegible]

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 1 month

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-15-67, 19__, *to* 10-10-67, 19__, *that I last saw the deceased alive on* 10-10-67, 19__, *and that death occurred at* 8:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] Dillon M.D. 141 (Degree or title)
23b. ADDRESS: American Falls, Idaho
23c. DATE SIGNED: 10-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Burial 3
24b. DATE: 10-13-67
24c. NAME OF CEMETERY OR CREMATORY: Valley View Cemetery
24d. LOCATION (City, town, or county) (State): Rockland, Idaho

DATE REC'D BY LOCAL REG.: 10-14-67
REGISTRAR'S SIGNATURE: Colleen Hadfield
25. EMBALMER: [illegible] Davis H. L. Davis — LICENSE NO. E-253

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Davis Furniture & Mortuary, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4633
Local Reg. No. 20
Reg. Dist. No. 500-602

RECEIVED OCT 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Power 390 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
LENGTH OF STAY (in this place) 1 yr. 10 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 737

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JOHN		LIESE	Oct. 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	May 26, 1884	83	4	17		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer - Retired 44 Farm		Totonia, Krimea, So. Russia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Liese	Unknown	Carolina (Unknown)	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-42-7807	William Liese	Am. Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4301

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 18 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2-12-, 1962, *to* 10-13-67, 19___, *that I last saw the deceased alive on* 10-13-, 19 67, *and that death occurred at* 1:50A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
T. Fulton MD	American Falls, Idaho	10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-16-67	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-18-67	Colleen Hadfield	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-6302A

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 27 2010

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4634
Local Reg. No. 61
Reg. Dist. No. 140

BIRTH NO.

RECEIVED STATE OF IDAHO

NOV 6 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Shoshone 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Wallace
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 405
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mullan
d. STREET ADDRESS (If rural, give location): 605 Hunter Street

3. NAME OF DECEASED (Type or Print): a. (First) Lawrence b. (Middle) Bruce c. (Last) Barton

4. DATE OF DEATH (Month) (Day) (Year): Sept. 25 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: April 8, 1953
9. AGE (In years last birthday): 14 (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Public School
11. BIRTHPLACE (State or foreign country): Wallace, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Thomas Barton
14. MOTHER'S MAIDEN NAME: Rose Ella Jackson
BIRTHPLACE
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Thomas L. Barton
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot Wound of Head — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs 25 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): about home
21c. (CITY, TOWN, OR TOWNSHIP) Mullan (COUNTY) Shoshone (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-25-67 7:15 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY Ooccur? Gun accidently went off.

22. *I hereby certify that I attended the deceased from* 9-25 *1967, to* 9-25 *1967, that I last saw the deceased alive on* 9-25 *1967, and that death occurred at* 9:40 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE: A. M. Peterson, M.D. (Degree or title)
23b. ADDRESS: Wallace, Idaho
23c. DATE SIGNED: 10-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Sept. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mullan Cemetery
24d. LOCATION (City, town, or county) (State): Mullan Idaho

DATE REC'D BY LOCAL REG.: Oct. 6, 1967
REGISTRAR'S SIGNATURE: Wade Cornell
25. EMBALMER: Derrell J. Juelfs
LICENSE NO.: E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4635
Local Reg. No. 62
Reg. Dist. No. 140

Certificate of Death

STATE OF IDAHO

RECEIVED
OCT 12 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 400
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location) 369 2nd Street

3. NAME OF DECEASED (Type or Print)
a. (First) IVAN
b. (Middle) NYAL
c. (Last) NORMAN

4. DATE OF DEATH (Month) (Day) (Year) October 3, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 1, 1914
9. AGE (In years last birthday) 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Wallace, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE
14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-03-0176
17. INFORMANT'S OWN SIGNATURE Byrdene Norman ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 3, 1967, *to* Oct 3, 1967, *that I last saw the deceased alive on* Oct 3, 1967, *and that death occurred at* about 4:26 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE 414 (Degree or title) A. M. Peterson, M.D.
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 10-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY DEBorgia Cemetery
24d. LOCATION (City, town, or county) (State) DeBorgia, Montana

DATE REC'D BY LOCAL REG. Oct. 9, 1967
REGISTRAR'S SIGNATURE Dale J. Cornell
25. EMBALMER Derrell J. Juelfs
LICENSE NO. E-518

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 13 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 23 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 10 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 13 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4636
Local Reg. No. 84
Reg. Dist. No. 142

BIRTH NO.

OCT 20 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 40 / Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 40 / Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 5 West Mill St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DORCY	N.	HECOCK	Oct. 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 23, 1884	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Carpenter 07	Mining	North Dakota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-03-2709	John J. Port	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Cerebral Vascular Disease	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hemiplegia	9-9-67
DUE TO (c)	Uraemia	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-9-67 *to* 10-3-67, *that I last saw the deceased alive on* 10-3, 67, *and that death occurred at* 3:05 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert Haley	MD	Kellogg Idaho	10-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 7, 1967	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-16-67	Jack Devine	Donald Maisel	E452

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4637
Local Reg. No. 63
Reg. Dist. No. 140

RECEIVED OCT 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 402 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway #10 River St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 400
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burke
d. STREET ADDRESS (If rural, give location): P.O. Box 195

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Robert	Lee	Jackson	Oct.	7,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	May 19, 1924	43				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Diamond Driller 07	Mining	Joplin, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John R. Jackson		Hazel Williams	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W.2 4	531-28-0671	Patricia L. Jackson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe Penetrating Wound of Right Face & Skull — Interval between onset and death: Few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
accident 1	Highway 10 & River St.	s/e Wallace	Shoshone	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
10-	7-	67	about 1:15 A.m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	automobile accident

22. *I hereby certify that I attended the deceased from* Oct 7, 19 67, *to* Oct 7, 19 67, *that I last saw the deceased alive on* Oct 7, 19 67, *and that death occurred at* about 1:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. M. Peterson, M.D. 414		Wallace, Idaho	10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 10, 1967	Shoshone Memorial Cem.	Pinehurst Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 13, 1967	Dale Cornell	Derrell J. Juelfs	E-518

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 17 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4638
Local Reg. No. 85
Reg. Dist. No. 142

Certificate of Death

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 309
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (in this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 400
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silver King
d. STREET ADDRESS (If rural, give location): Box 267 Smelterville, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): Launa
b. (Middle): E.
c. (Last): Wadehul

4. DATE OF DEATH (Month) (Day) (Year): Oct. 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 22, 1913
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): East St. Louis, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Burt C. Ellis — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Estella Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None 180X
16. SOCIAL SECURITY NO.: 518-48-0599
17. INFORMANT'S OWN SIGNATURE: Vernon Wadehul — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Adeno-carcinoma R. Kidney — INTERVAL BETWEEN ONSET AND DEATH: 3 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): —
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 8.16.67
19b. MAJOR FINDINGS OF OPERATION: Large Adeno-ca. R. Kidney
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Aug 7 – October, 1967, *to* Oct 7, 1967, *that I last saw the deceased alive on* Oct 7, 1967, *and that death occurred at* 8:05 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 052 (Degree or title): Bourbahr MD
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 10.9.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: Oct. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY: Smith Crematory
24d. LOCATION (City, town, or county) (State): Spokane, Wash.

DATE REC'D BY LOCAL REG.: 10-16-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Robert G. Ross — LICENSE NO. E-497
FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-10259 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4639
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

OCT 25 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 401 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) few min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 485 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
d. STREET ADDRESS (If rural, give location) Box 104 Pinehurst, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) BABY BOY b. (Middle) c. (Last) MARTENS

4. DATE OF DEATH (Month) (Day) (Year) Oct. 7, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Oct. 7, 1967

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days 1 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Linda Lou Martin — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Linda Martens — ADDRESS Pinehurst, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 776X Prematurity. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Kellogg Shoshone Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth 10-7-67, 19__, *to* 10-7-, 1967, *that I last saw the deceased alive on* 10-7-, 1967, *and that death occurred at* 6:55 A m., *from the causes and on the date stated above.*

23a. SIGNATURE [illegible] Dale 765 (Degree or title) MD

23b. ADDRESS Kellogg, Idaho.

23c. DATE SIGNED 10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY Greenwood

24d. LOCATION (City, town, or county) Kellogg. (State) Idaho

DATE REC'D BY LOCAL REG. 10-24-67

REGISTRAR'S SIGNATURE [illegible]

25. EMBALMER [signature] LICENSE NO. E452

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4640
Local Reg. No. 64
Reg. Dist. No. 140

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 402 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
LENGTH OF STAY (If this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 402 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): Pacific Hotel

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	John	Posie	Walker	Oct. 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	Feb. 14, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mill Operator of	Mining	Wilkes County, N. Carolina	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Walker	Unknown	Annie Mathis	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	574-01-2703	Mrs. Irene Reinhardt	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 9 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — Several years

DUE TO (c) Hypertensive Cardiovascular — Several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Renal Disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-1-, 1967, *to* 10-8, 1967, *that I last saw the deceased alive on* 10-8, 1967, *and that death occurred at* 3:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. M. Peterson	414 M.D.	Wallace, Idaho	10-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 12, 1967	Pleasant Grove	Wilkes County No. Car.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 13, 1967	Ward Cornell	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4641
Local Reg. No. 66
Reg. Dist. No. 140

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 402
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400 COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Gem
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Batista b. (Middle) --- c. (Last) Franzoi

4. DATE OF DEATH (Month) (Day) (Year) Oct. 12 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH January 22, 1888

9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Roncone, Italy

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Philipo Franzoi BIRTHPLACE Italy

14. MOTHER'S MAIDEN NAME Santina Prandi BIRTHPLACE Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 535-18-0280

17. INFORMANT'S OWN SIGNATURE Louis Branz ADDRESS Gem, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9037

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Severe Contusion of lumbo-sacral spine & left hip — 10 days

DUE TO (c) Fibrosis of Cyst, severe advanced osteoporosis of lumbo-sacral back — several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cachexia - several months — several years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Shoshone Co. Nursing Home

21c. (CITY, TOWN, OR TOWNSHIP) Silverton 400 13 (COUNTY) Shoshone (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 9-28-67 11:55p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Apparently fell. Was found on parlor floor.

22. I hereby certify that I attended the deceased from Sept 26, 1966, to Oct 12, 1967, that I last saw the deceased alive on Oct 12, 1967, and that death occurred at 1:55 p.m., from the causes and on the date stated above.

23a. SIGNATURE C. M. Peterson, M.D. (Degree or title) 414

23b. ADDRESS Wallace, Idaho

23c. DATE SIGNED Oct. 19, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 24, 1967

24c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery

24d. LOCATION (City, town, or county) Trentwood (State) Washington

DATE REC'D BY LOCAL REG. Oct 20-67

REGISTRAR'S SIGNATURE Ward Cornell

25. EMBALMER Derrell J. Juelfs

LICENSE NO. E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4642
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

OCT 25 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 006
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
LENGTH OF STAY (in this place): few min.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Shoshone 410
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pinehurst
d. STREET ADDRESS (If rural, give location): 415 4th. Street

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. West Shoshone Gen.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JAMES	ORVAL	HAYES	Oct.	15,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 24, 1901	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Switch Foreman	10 Railroad	Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lyman M. Hayes	Illinois	Helen B. Williamson	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	701-09-0107	Deanna M. Hayes	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct 15 1967 *to* Oct 15, 1967, *that I last saw the deceased alive on* Oct 15, 1967, *and that death occurred at about* 11:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
T. M. Peterson, M.D. 414	Wallace, Idaho	10-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct. 17, 1967	Forest Lawn Cem.	Seattle, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-24-67	Joe Peterson	Donald Maisel	E452

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

OCT 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4643
Local Reg. No. 65
Reg. Dist. No. 140

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 402 313
b. CITY OR TOWN: Wallace
LENGTH OF STAY (in this place): 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 38 Oregon
b. COUNTY: 355 Umatilla
c. CITY OR TOWN: Milton-Freewater
d. STREET ADDRESS (If rural, give location): Rt. 2 Box 342

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Edward	---	LeFore	Oct.	16	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	April 6, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael LeFore — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 540-44-6437
17. INFORMANT'S OWN SIGNATURE: X Mrs Anne Otte — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerotic Heart disease — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Cerebral Concussion, subsequent inanition & Cachexia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 3 Oct, 1967, *to* 16 Oct, 1967, *that I last saw the deceased alive on* 6 Oct, 1967, *and that death occurred at* 10:20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William N. Dye M.D. 672	Wallace Idaho	17 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 19, 1967	Milton-Freewater Cem	Milton-Freewater Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct. 17, 1967	Dale Harnell	Derrell J. Juelfs	E-518

FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 15 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4644
Local Reg. No. 67
Reg. Dist. No. 140

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 6 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Hospital 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 280 ~~400~~
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rose Lake
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): Augusta
c. (Last): Ash

4. DATE OF DEATH (Month) (Day) (Year): Oct. 19, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: July 27, 1885
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bunker Hill 21
10b. KIND OF BUSINESS OR INDUSTRY: Smelter
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-16-2411
17. INFORMANT'S OWN SIGNATURE: Hospital Records — ADDRESS:

18. CAUSE OF DEATH 5271
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH: many years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility + malnutrition — 2 years.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 February, 1955, *to* 19 October, 1967, *that I last saw the deceased alive on* 19 October, 1967, *and that death occurred at* 8:40 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert W. Cordwell, M.D. 105 1
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 20 Oct 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Oct. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rose Lake Cemetery
24d. LOCATION (City, town, or county) (State): Rose Lake Idaho

DATE REC'D BY LOCAL REG.: 10-27-67
REGISTRAR'S SIGNATURE: Dale L Cornell
25. EMBALMER: Dale L Cornell — LICENSE NO. E406

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: CORNELL-WARD

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4645
Local Reg. No. 88
Reg. Dist. No. 142

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 6 1967

1. PLACE OF DEATH a. COUNTY: Shoshone 400	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho 401 b. COUNTY: Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Silverton c. LENGTH OF STAY: Bureau of Vital Statistics	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): County Nursing Home 138	d. STREET ADDRESS (If rural, give location): Kellogg Hotel

3. NAME OF DECEASED (Type or Print)	a. (First): HALVAR	b. (Middle):	c. (Last): HANSON
4. DATE OF DEATH	(Month) (Day) (Year): Oct. 20, 1967		
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4	
8. DATE OF BIRTH: March 28, 1886	9. AGE (In years last birthday): 81	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Zinc Plant Man	10b. KIND OF BUSINESS OR INDUSTRY: 07 Mining	11. BIRTHPLACE (State or foreign country): Norway	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Unknown	BIRTHPLACE: Unknown	14. MOTHER'S MAIDEN NAME: Unknown	BIRTHPLACE: Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes, give war or dates of service): None	16. SOCIAL SECURITY NO.: 518-09-7047	17. INFORMANT'S OWN SIGNATURE: Personal Records; ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Malnutrition — 6 months
DUE TO (c) Senility — 7 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. no

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) Kellogg (COUNTY) Shoshone (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6 apr, 1959 *to* 20 oct, 1967, *that I last saw the deceased alive on* 12 oct, 1967, *and that death occurred at* — *m., from the causes and on the date stated above.*

23a. SIGNATURE: Glen M. Whitsell	539 (Degree or title): MD	23b. ADDRESS: Kellogg, Idaho	23c. DATE SIGNED: 30 oct 67
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: Oct. 25, 1967	24c. NAME OF CEMETERY OR CREMATORY: Greenwood	24d. LOCATION (City, town, or county): Kellogg, (State): Idaho
DATE REC'D BY LOCAL REG.: 11/3/67	REGISTRAR'S SIGNATURE: Joe Irvine	25. EMBALMER: [signature]	LICENSE NO.: 452

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: MAISEL FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 1 1967 Bureau of Vital Statistics

State File No. 4646
Local Reg. No. 68
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 402 Shoshone 000
b. CITY OR TOWN Wallace
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN Mullan
d. STREET ADDRESS (If rural, give location) 451 2nd Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Jess	George	Noordam	Oct. 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	11-6-1914	52	11	18		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mining 07	Mining Galena	Phillips, Mon. County, Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Noordam		May V. Freestone	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Army WW2 4	517-22-1201	Mary a noordam	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bronchogenic Carcinoma of Lung & Metastases — INTERVAL BETWEEN ONSET AND DEATH: 4 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-14, 1966, *to* 10-24, 1967, *that I last saw the deceased alive on* 10-24, 1967, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. M. Peterson	414, M.D.	Wallace, Idaho	10-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-27-67	Mullan	Mullan, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-27-67	Dale Cornell	Dale L. Cornell	E406

FIRM NAME: Cornell's Ward Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

F.

Certificate of Death

STATE OF IDAHO

State File No. 4647
Local Reg. No. 69
Reg. Dist. No. 140

BIRTH NO.

RECEIVED NOV 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 402 Shoshone
b. CITY OR TOWN Wallace
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 488 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Oscar b. (Middle) --- c. (Last) Erickson

4. DATE OF DEATH (Month) (Day) (Year) Oct, 25, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH 7-29-1878

9. AGE (In years last birthday) 89 IF UNDER 1 YEAR Months 2 Days 26 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Millman 07

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Fergus Falls, Minnesota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown BIRTHPLACE

14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 556-10-4678

17. INFORMANT'S OWN SIGNATURE Hannah Truesdell ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION 4222

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Chronic — INTERVAL BETWEEN ONSET AND DEATH Months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Cerebral Sclerosis — WEEKS-

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* 10-24, 1967, *that I last saw the deceased alive on* 10-23, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE 168 (Degree or title)

23b. ADDRESS Wallace Idaho

23c. DATE SIGNED Oct. 26, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) 10-28-1967

24b. DATE 10-28-67 Cremation

24c. NAME OF CEMETERY OR CREMATORY Smith & Co.

24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. 10-27-67

REGISTRAR'S SIGNATURE Dale L. Cornell

25. EMBALMER Dale L. Cornell LICENSE NO. E 406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4648
Local Reg. No. 90
Reg. Dist. No. 141

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 40 Shoshone 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. West Shoshone Gen

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 40
b. COUNTY Shoshone 002
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Smelterville
d. STREET ADDRESS (If rural, give location) 108 E. Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
GARY	R. 000	NOTTINGHAM	Oct. 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 13, 1939	27				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	Casper, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Donald Nottingham		Hazel Chapman	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes 1959 - 1962	518-44-6306	Mrs Helen Nottingham	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Penetrating wounds & foreign bodies of skull, face, neck, chest & both upper extremities — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Severe Compound, comminuted fracture of left humerus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 40 (STATE)
accident 1	mine 11	Kellogg, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
10-25-67 about 9:30 a.m.		Blast Injury

22. *I hereby certify that I attended the deceased from* 10-25 1967, to 10-25, 1967, *that I last saw the deceased alive on* 10-25, 1967, *and that death occurred at* about 9:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. M. Peterson, M.D. 414	Wallace Idaho	10-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial 1	Oct. 28, 1967	Pinecrest	Sandpoint, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11/3/67	Joe Simms	Robert H. Ross	E-497

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 12 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining [illegible] signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4649
Local Reg. No. 89
Reg. Dist. No. 142

Certificate of Death

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Shoshone 401 308
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kellogg
c. LENGTH OF STAY (In this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 400
b. COUNTY: Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kingston
d. STREET ADDRESS (If rural, give location): Kingston, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First): ETHEL
b. (Middle):
c. (Last): PETERSEN

4. DATE OF DEATH (Month) (Day) (Year): Oct. 27, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Mar. 26, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Wilcott — BIRTHPLACE: Wisconsin
14. MOTHER'S MAIDEN NAME: Lilac Grieves — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-20-9727x
17. INFORMANT'S OWN SIGNATURE: Sig. Petersen — ADDRESS:

18. CAUSE OF DEATH 157X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Terminal Cremer — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Metastatic Ca of Pancreas — 10 months
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Kellogg Shoshone Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 16 Oct, 1967, *to* 27 Oct, 1967, *that I last saw the deceased alive on* 27 Oct, 1967 *and that death occurred at* 6:40 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Glen M. Whitlow 539 (Degree or title) MD
23b. ADDRESS: Kellogg, Idaho
23c. DATE SIGNED: 30 Oct 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Oct. 31, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn
24d. LOCATION (City, town, or county) (State): Coeur D'Alene, Idaho

DATE REC'D BY LOCAL REG.: 11/3/67
REGISTRAR'S SIGNATURE: Joe [illegible]
25. EMBALMER: Robert G. Ross — LICENSE NO.: E-497

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: MAISEL FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4650
Local Reg. No. 7
Reg. Dist. No. 620

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Teton 4/0 OCT 13 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give) 5 mi No of Driggs
c. LENGTH OF STAY (Bureau of Vital Statistics) —
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Highway # 33 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Durango 52
b. COUNTY 555 —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Tiahualilo de Zaragoza
d. STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print) a. (First) José b. (Middle) c. (Last) Calderón

4. DATE OF DEATH (Month) Oct (Day) 1, (Year) 1967

5. SEX Male
6. COLOR OR RACE Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH unknown
9. AGE (In years last birthday) 25 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY —
11. BIRTHPLACE (State or foreign country) Tiahualilo, Mexico
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME unknown BIRTHPLACE
14. MOTHER'S MAIDEN NAME unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) m (If yes, give war or dates of service) m
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Family Records ADDRESS R. Bean

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8354

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture Vetebral Column at base of skull — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture of Right Arm
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 5 mi. No. of Driggs
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 4/0 (STATE) Teton Co. Idaho

21d. TIME OF INJURY (Month) Oct. (Day) 1. (Year) 1967 (Hour) 10 a.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑ 2
21f. HOW DID INJURY OCCUR? Auto Accident

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE A. J. Greene 583 (Degree or title) Coroner 4
23b. ADDRESS Driggs, Idaho
23c. DATE SIGNED 10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 3 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY Driggs Cemetery
24d. LOCATION (City, town, or county) (State) Driggs Teton Co, Idaho

DATE REC'D BY LOCAL REG. 10-10-67
REGISTRAR'S SIGNATURE Ella Driggs
25. EMBALMER Robert Q. Bean LICENSE NO. E-456
FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4651
Local Reg. No. 8
Reg. Dist. No. 620

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED OCT 13 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Teton 410 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 410
b. COUNTY: Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Driggs
d. STREET ADDRESS (If rural, give location): None Given

3. NAME OF DECEASED (Type or Print)
a. (First): BARTELL
b. (Middle):
c. (Last): CHRISTENSEN

4. DATE OF DEATH (Month) (Day) (Year): October 2, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 10, 1917
9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months 6, Days 22 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Blacksmith/Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: Repair Shop
11. BIRTHPLACE (State or foreign country): Driggs, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Orson W. Christensen — BIRTHPLACE: Cache Valley, Utah
14. MOTHER'S MAIDEN NAME: Loretta Hochstrasser — BIRTHPLACE: Providence, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 518-05-8413
17. INFORMANT'S OWN SIGNATURE: Betty Jean Christensen — ADDRESS: Driggs, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4518

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Dissecting Thoracic Aneurysm — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1961, *to* 10-2, 1967, *that I last saw the deceased alive on* 10-2, 1967, *and that death occurred at* 8:30A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): K. Head MD 219
23b. ADDRESS: Driggs Idaho
23c. DATE SIGNED: 10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 5 Oct. 67
24c. NAME OF CEMETERY OR CREMATORY: Driggs Cemetery
24d. LOCATION (City, town, or county) (State): Driggs, Teton Co., Idaho

DATE REC'D BY LOCAL REG.: 10-10-67
REGISTRAR'S SIGNATURE: Ella Griggs
25. EMBALMER: Robert Q. Bean
LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bean Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4652
Local Reg. No. D-343
Reg. Dist. No. 460

RECEIVED
Bureau of Vital Statistics
OCT 9 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls
b. CITY OR TOWN Twin Falls
LENGTH OF STAY IN HOSPITAL
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN Eden
d. STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print)
a. (First) Odaus
b. (Middle)
c. (Last) Fitzpatrick

4. DATE OF DEATH (Month) (Day) (Year) October 1, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 28, 1892
9. AGE (In years last birthday) 75
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Clark Ridge, Arkansas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John Fitzpatrick
BIRTHPLACE Ark.
14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 432-38-8072
17. INFORMANT'S OWN SIGNATURE Harold Fitzpatrick
ADDRESS Eden, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adrenal insufficiency due to adrenal hemorrhage.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Massive gastro-intestinal hemorrhage site undetermined.

DUE TO (c) Peritonitis secondary to perforation of colon.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Post-operative duodenal fistula following gastric resection.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 9-7, 25, 27, 1967
19b. MAJOR FINDINGS OF OPERATION Duodenal fistula following gastrectomy done on 9-7-67 with massive GI hemorrhage 9-23-67. Perforation of colon 9-27-67.
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-25, 1963, *to* 10-1, 1967, *that I last saw the deceased alive on* 10-1, 1967, *and that death occurred at* 2:24P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 622 M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 10/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial Removal
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY Thacker Cem.
24d. LOCATION (City, town, or county) Mt. Home, (State) Arkansas

DATE REC'D BY LOCAL REG. 10/6/67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Edgar Robertson
LICENSE NO. E-507
FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4653
Local Reg. No. D-349
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 12 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls Buhl
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harrall Rest Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 176 Carney

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Robert
c. (Last): Weise

4. DATE OF DEATH (Month) (Day) (Year): October 1, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 12, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired cement finisher 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Smith Center, Kansas
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: UNK — BIRTHPLACE: UNK
14. MOTHER'S MAIDEN NAME: UNK — BIRTHPLACE: UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): —o—
16. SOCIAL SECURITY NO.: 517-07-7989A
17. INFORMANT'S OWN SIGNATURE: FROM RECORDS By R. Mikel — ADDRESS: Twin Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Coronary arteriosclerosis — 2 years
DUE TO (c): Gen. Arteriosclerosis — 5 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Carcinoma of prostate — 1 yr

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-19-65, 19__, *to* 10-1-67, 19__, *that I last saw the deceased alive on* 10-1-67, 19__, *and that death occurred at* 12-50p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. H. Clark 092 MD 1
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 10.3.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 10.4.67
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cem.
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 10-10-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: [signature]
LICENSE NO.: 343

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: White Mortuary Twin Falls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4654
Local Reg. No. D-346
Reg. Dist. No. 460

RECEIVED
OCT 9 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN Twin Falls 83301
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 421 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) Skyview Manor Filer Ave. West

3. NAME OF DECEASED (Type or Print) a. (First) Katherine b. (Middle) c. (Last) Heil

4. DATE OF DEATH (Month) (Day) (Year) October 3, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Feb. 26, 1886

9. AGE (In years last birthday) 81
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Of home

11. BIRTHPLACE (State or foreign country) Romania

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jacob Grentz
BIRTHPLACE UNK

14. MOTHER'S MAIDEN NAME UNK.
BIRTHPLACE UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-12-2414B

17. INFORMANT'S OWN SIGNATURE X Lawrence Heil
ADDRESS Eastleford, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis
INTERVAL BETWEEN ONSET AND DEATH 2 Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
a few hrs before death

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__ *to* 10-3, 1967, *that I last saw the deceased alive on* 10-3, 1967, *and that death occurred at* 9:25 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [illegible] M.D.

23b. ADDRESS 294 Homedale Ave

23c. DATE SIGNED 10-04-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 6, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. 10/6/67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Ronald D. Hamilton
LICENSE NO. E-498

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4655
Local Reg. No. 0347
Reg. Dist. No. 460

BIRTH NO.

RECEIVED OCT 12 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls — LENGTH OF STAY (in this place) 4 days 304
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 140 — b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parma (Rural)
d. STREET ADDRESS (If rural, give location) Route # 2

3. NAME OF DECEASED (Type or Print) — a. (First) HOWARD — b. (Middle) — c. (Last) KOCH

4. DATE OF DEATH (Month) (Day) (Year) Oct. 3, 1967

5. SEX male — 6. COLOR OR RACE white — 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3 — 8. DATE OF BIRTH May 29, 1912 — 9. AGE (In years last Birthday) 55 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer 04 — 10b. KIND OF BUSINESS OR INDUSTRY agriculture — 11. BIRTHPLACE (State or foreign country) Missouri — 12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Phillip N. Koch — BIRTHPLACE Ill.

14. MOTHER'S MAIDEN NAME Estella Barnhart — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - - - -

16. SOCIAL SECURITY NO. 518-12-6300

17. INFORMANT'S OWN SIGNATURE Howard L Koch — ADDRESS Parma, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 2 mo +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Glomerulonephritis — 5 yrs +
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Gastro intestinal Hemorrhage — 4 days +

19a. DATE OF OPERATION - - - -
19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) - - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - - - - - - - -
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) - - - - - - - - - - - -
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* 29 Sept, 1967, *to* 3 Oct, 1967, *that I last saw the deceased alive on* 3 Oct, 1967, *and that death occurred at* 9:20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE James H. Spafford 489 (Degree or title) M.D. — 23b. ADDRESS Twin Falls, Idaho — 23c. DATE SIGNED 10/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial — 24b. DATE 10-6-67 — 24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park — 24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10/6/67 — REGISTRAR'S SIGNATURE Pamela J. Johnson — 25. EMBALMER Dale R. Patterson — LICENSE NO. E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 1 6 1967

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4656
Local Reg. No. D-337
Reg. Dist. No. 460

RECEIVED OCT 12 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): 035
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 254 Lois

3. NAME OF DECEASED (Type or Print): a. (First) Josie b. (Middle) Mabel 143 c. (Last) Howard

4. DATE OF DEATH: (Month) (Day) (Year): October 4, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 2, 1893

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Whiting, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Theodore Franklin Parrott
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Mary Jane Banks
BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 518-60-3575K

17. INFORMANT'S OWN SIGNATURE: X Hazel Schnell
ADDRESS: Rogerson, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral arteriosclerosis -
INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1952, *to* Oct 4, 1967, *that I last saw the deceased alive on* Oct 4, 1967 *and that death occurred at* 6:20 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Jean H. Affleck MD

23b. ADDRESS: 234 4th Ave. North Twin Falls Idaho

23c. DATE SIGNED: 6 October 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 7, 1967

24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 10-10-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Jerry D. Holman

LICENSE NO.: E-516

FIRM NAME: White Mortuary 7336600

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4657
Local Reg. No. 0-348
Reg. Dist. No. 40

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 83301 OCT 12 1967 — b. CITY OR TOWN Twin Falls — c. LENGTH OF STAY IN THIS PLACE 2 WKS
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hosp. 443

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY 421 Twin Falls — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 156 Austin

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LUCY	CAROLINE	MORRIS	Oct. 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	Sept. 16, 1886	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Homemaker 01	Own home	Hartwell, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Edward Ellis	Illinois	Flora Hetzler	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE
no	519-10-7447	Mrs. W. A. Morris Twin Falls, Idaho 83301

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIsignificant CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

332X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-20, 1967, *to* 10-4, 1967, *that I last saw the deceased alive on* 10-4, 1967, *and that death occurred at* 1:30p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. W. Kendall M.D.	Twin Falls, Idaho 83301	10-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Oct 7, 1967	Minden, Cemetery	Minden, Nebraska

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10/6/67	Pamela J. Johnson	William J. Boyd	E-490

Federal Security Agency
United States Public Health Service

Form DH-65021

FIRM NAME: Twin Falls Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-8187
BIRTH NO.

Certificate of Death

RECEIVED
OCT 16 1967
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4658
Local Reg. No. D-356
Reg. Dist. No. 460

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 43

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 160
b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Elba
d. STREET ADDRESS (If rural, give location) **********

3. NAME OF DECEASED (Type or Print)
a. (First) Cory
b. (Middle) Lee
c. (Last) Darrington

4. DATE OF DEATH (Month) (Day) (Year) Oct. 6, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Aug. 30, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 1 Days 6 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Reo Darrington — BIRTHPLACE Elba, Idaho
14. MOTHER'S MAIDEN NAME Jolene Nell Rasmussen — BIRTHPLACE Los Angeles, Cal.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE John R Darrington — ADDRESS Elba

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3400

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis, Acute Hemophilus influenzae. — INTERVAL BETWEEN ONSET AND DEATH 2 d.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/5, 1967, *to* 10/6, 1967, *that I last saw the deceased alive on* 10/6, 1967, *and that death occurred at* 4:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE E. M. Wright 576 (Degree or title) M.D.
23b. ADDRESS 676 Kroupa Ave W Twin Falls Idaho
23c. DATE SIGNED 10/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 10/9/67
24c. NAME OF CEMETERY OR CREMATORY Elba Cemetery
24d. LOCATION (City, town, or county) (State) Elba, Idaho

DATE REC'D BY LOCAL REG. 10-12-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER J. Barth Payne
LICENSE NO. E-389

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Payne Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to:

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4659
Local Reg. No. D-354
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

OCT 12 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If not in place) 2½ yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sky View Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 228 3rd Ave. N.

3. NAME OF DECEASED (Type or Print)
a. (First) MARY
b. (Middle) ELSIE
c. (Last) MOREHOUSE

4. DATE OF DEATH (Month) (Day) (Year) Oct. 8, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Jan. 15, 1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY Public schools
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joel Halbert — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME unkn — BIRTHPLACE unkn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - - - - -
16. SOCIAL SECURITY NO. 518-14-1172
17. INFORMANT'S OWN SIGNATURE Pocatello x Marcha Sorensen — ADDRESS Idaho

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary Heart attack — INTERVAL BETWEEN ONSET AND DEATH: 6 Mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic myocarditis
DUE TO (c) Hypertensive cardiovascular disease. — 10 Years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - - - - - -
21c. (CITY, TOWN, OR TOWNSHIP) - - - - - - (COUNTY) - - - - (STATE) - - - -
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* April 24, 1964, *to* Oct. 8, 1967, *that I last saw the deceased alive on* Sept. 23, 1967, *and that death occurred at* 10:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 246 (Degree or title) Glenn A. Hoss, MD
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED Oct. 10, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 10-11-67
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10-11-67
REGISTRAR'S SIGNATURE Pamela Johnson
25. EMBALMER Dale P. Patterson
LICENSE NO. E-451
FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4660
Local Reg. No. 0-353
Reg. Dist. No. 460

BIRTH NO. OCT 12 1967

1. PLACE OF DEATH
a. COUNTY 42 / Twin Falls 83301 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 14 3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 1416 Addison Ave East

3. NAME OF DECEASED (Type or Print) a. (First) ETHEL b. (Middle) MAY c. (Last) HELMBOLT

4. DATE OF DEATH (Month) (Day) (Year) October 9, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH September 16, 1905

9. AGE (In years last birthday) 62 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Middleton, Idaho

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Albert O. McGrath — BIRTHPLACE Ohio

14. MOTHER'S MAIDEN NAME Susan Josephine Hughes — BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-09-6022

17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS 83301 TwinFalls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Primary Sarcoma of Vagina — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Abdominal Metastates — Dec. 1966
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Left Breast — 1963

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-25 *1965, to* 9-9 *, 1967, that I last saw the deceased alive on* 9-9 *, 1967, and that death occurred at* 4.50P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) **23b. ADDRESS** Twin Falls, Idaho **23c. DATE SIGNED** 10.10.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** 10.12.67 **24c. NAME OF CEMETERY OR CREMATORY** Twin Falls Cemetery **24d. LOCATION** (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. 10-11-67 **REGISTRAR'S SIGNATURE** Pamela J. Johnson

25. EMBALMER [signature] LICENSE NO. 343

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-03021

DUTIES:

OCT 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4661
Local Reg. No. 0-358
Reg. Dist. No. 460

BIRTH NO.

RECEIVED OCT 16 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 42 / Twin Falls

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hospital 1444

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 42

b. COUNTY Twin Falls

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Twin Falls 83301

d. STREET ADDRESS (If rural, give location) Grand View Drive (Trailer Courts)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JULIA	E.	McCALMON	October 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Caucasian	Married 3	January 31, 1905	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Missouri Arcada, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lue Moore	Mo.	Lille Moore	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Leon Mel McCalmon	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — Interval between onset and death: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Bronchial Asthma Intermittent — all her life

DUE TO (c) Pulmonary Tuberculosis — 6 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3-26, 1967, *to* 10-10, 1967, *that I last saw the deceased alive on* 10-10, 1967, *and that death occurred at* 7:50A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
D.A. McQuarrie MD 336	Twin Falls Idaho	10/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 13, 1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-12-67	Pamela L. Johnson		E-343

Federal Security Agency
United States Public Health Service

Form DH-65021

FIRM NAME: WHITE MORTUARY 733-6600

OCT 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4662
Local Reg. No. P 365
Reg. Dist. No. 460

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and township): Twin Falls
c. LENGTH OF STAY (in this place): 44 3
d. FULL NAME OF HOSPITAL OR INSTITUTION: MAGIC VALLEY MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 832 12th Avenue North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LAUREN	W.	SHRIVER	Oct. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	December 26, 1913	53				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Buhl, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Walter M. Shriver	Kansas	Nettie Funk	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-42-6472	Mrs Dorothy Shriver	832 12th N. Buhl

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Perforated Gastric Ulcer — INTERVAL BETWEEN ONSET AND DEATH: 3 1/2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Gastric Ulcer. — 3 yrs.

DUE TO (c) Severe Chronic Emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. + Pulmonary Hypertension 15 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-6, 1967, *to* 10-10-67 19___, *that I last saw the deceased alive on* 10-10, 1967, *and that death occurred at* 10:10 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. H. Anderson M.D.	Buhl, Idaho	10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/12/67	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10/23/67	Pamela J. Johnson	George Farmer	E-480

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 15 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4653
Local Reg. No. D-359
Reg. Dist. No. 460

RECEIVED
OCT 16 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 42/Twin Falls

b. CITY OR TOWN (If outside corporate limits, write RURAL and give TOWNSHIP): Twin Falls

c. LENGTH OF STAY (In this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 780 Maurice Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: 42/T.Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

d. STREET ADDRESS (If rural, give location): 780 Maurice Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
NETTIE	P.	LAKE	October 11,1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	March 13,1886	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): LaMar,Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph H.Price — BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Esther Battcey — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-26-9304

17. INFORMANT'S OWN SIGNATURE: Carl H. Lake — ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c) Old Age

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1966, *to* 10/11/, 1967, *that I last saw the deceased alive on* 10-9-, 1967, *and that death occurred at* 3:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Thad Scholes	M.D.	Twin Falls, Idaho	10-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/13/67	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-12-67	Pamela J. Johnson	James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4664
Local Reg. No. D-357
Reg. Dist. No. 460

RECEIVED
OCT 16 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 415 3rd Ave So.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 415 3td Ave South

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Dolly	Marlena	Berry	October 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Jan. 21, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Dora, Missouri	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wm. Parley	~~Unknown~~ Unknown	Unknown Street	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518 32 7270	C J Berry	TwinFalls, Idaho

4281

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Myocardial Infarction	1 hr
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes Mellitus	4 yrs
	Congestive Heart failure	3 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7 Nov, 19 66, *to* 11 Oct, 19 67, *that I last saw the deceased alive on* 10 Oct, 19 67, *and that death occurred at* 10:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
489 James H. Spofford M.D.	Twin Falls, Idaho	10.12.67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10.14.67	Sunset Memorial Park Cem.	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-12-67	Pamela J. Johnson		343

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4665
Local Reg. No. D-360
Reg. Dist. No. 460

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 20 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 3½ yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazel Del Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 344 N. 5th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) CROSBY
b. (Middle) LAWRENCE
c. (Last) BIGGERSTAFF

4. DATE OF DEATH (Month) (Day) (Year) Oct. 14, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH June 10, 1882
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer (retired)
10b. KIND OF BUSINESS OR INDUSTRY 04 agriculture
11. BIRTHPLACE (State or foreign country) Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Isaac Biggerstaff — BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Betty Fanning — BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) 0 - - - -
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Murtaugh, + C.C. Biggerstaff — ADDRESS Idaho

18. CAUSE OF DEATH 260X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal cardiac failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gen arteriosclerosis diabetes + old age
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) - - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1964, *to* Oct 14, 1967 *that I last saw the deceased alive on* Oct 14, 1967 *and that death occurred at* 4 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE M.A. Drake M.D. 146 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 10-17-1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10-16-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Dale P. Patterson
LICENSE NO. E-451

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: TWIN FALLS MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4666
Local Reg. No. 0-36
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH — OCT 20 1967

a. COUNTY 421 Twin Falls 310

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls | LENGTH OF STAY (in this place) 10 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 1413

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho b. COUNTY 421 Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

d. STREET ADDRESS (If rural, give location) 203-4th St. North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	SAMUEL		RABIN	Oct. 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 18, 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tailor 21	Clothing	Rochester, New York	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	345-05-2862	Samuel Rabin	TwinFalls, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Duodenal Intestinal Bleeding — INTERVAL BETWEEN ONSET AND DEATH 20 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Ulcer Duodenal Intestinal Tract Perforation

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9- *, 1967, to* 10-14 *, 1967, that I last saw the deceased alive on* 10-14, 1967 *, and that death occurred at* 12:30a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Barry J. Brumbach 064	MD	Twin Falls, Idaho	10-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	Oct. 17, 1967	Mtn. View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-16-67	Pamela J. Johnson	Dale R. Pattison	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4667
Local Reg. No. D-376
Reg. Dist. No. 460

RECEIVED
OCT 30 1967
Bureau of Vital Stat. Dept.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clenic 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 070
b. COUNTY Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Gannett
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) George
b. (Middle) Edward
c. (Last) McGonigal

4. DATE OF DEATH (Month) (Day) (Year) Oct. 14, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 28, 1930
9. AGE (In years last birthday) 37 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Gannett, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George P. McGonigal — BIRTHPLACE UNK.
14. MOTHER'S MAIDEN NAME Mary Brown — BIRTHPLACE UNK.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) Korean 7
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mary Louise McGonigal — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 2 da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-12-67, 19__, *to* 10-14-67, 19__, *that I last saw the deceased alive on* 10-14-67, 19__, *and that death occurred at* 8:30 p *m., from the causes and on the date stated above.*

23a. SIGNATURE Joseph W. Marshall 330 (Degree or title) M.D. 1
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY Bellevue Cemetery
24d. LOCATION (City, town, or county) (State) Bellevue Idaho

DATE REC'D BY LOCAL REG. 10-26-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Keith Bird Keith Bird — LICENSE NO. E 373
FIRM NAME: Bird Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 27 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4668
Local Reg. No. D-367
Reg. Dist. No. 460

RECEIVED
OCT 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 / Twin Falls 000
b. CITY OR TOWN Twin Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42 / Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 226½ No. Washington

3. NAME OF DECEASED (Type or Print) a. (First) HAROLD b. (Middle) E. c. (Last) HINE

4. DATE OF DEATH (Month) (Day) (Year) Oct. 14, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH Dec. 21, 1907

9. AGE (In years last birthday) 59
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer

10b. KIND OF BUSINESS OR INDUSTRY 04 Farming

11. BIRTHPLACE (State or foreign country) Cedar Grove, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William F. Hine
BIRTHPLACE Iowa

14. MOTHER'S MAIDEN NAME Emma McFarland
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ----

16. SOCIAL SECURITY NO. 518-18-6272

17. INFORMANT'S OWN SIGNATURE Gloria Gilbert
ADDRESS Wendell, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ACUTE PULMONARY EDEMA — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Bronchial Asthma — 24 hrs.

DUE TO (c) Chronic pulmonary Emphysema — 10 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 1951 *to* Oct. 14, 1967, *that I last saw the deceased alive on* Oct. 14, 1967, *and that death occurred at* 11:50 PM, *from the causes and on the date stated above.*

23a. SIGNATURE O. Ellis Knight (Degree or title) M.D.

23b. ADDRESS Kimberly, Idaho

23c. DATE SIGNED 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 18, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10-18-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER

LICENSE NO. 343

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUN 1 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4669
Local Reg. No. D-368
Reg. Dist. No. 420

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Buhl
LENGTH OF STAY (in this place) Seconds
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Rural Route 4 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 1714 West Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Charles	LeRoy	Brinkman	Oct. 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	Aug. 21, 1945	22		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Tire Repairman 25	Tire Sales	Modesto, California	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ras Brinkman	Arkansas	Ollie Ross	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	560-64-9582	x Ras Brinkman	Buhl, Idaho 83316

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH: 8 mon.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb 1967 *to* Oct 14, 1967, *that I last saw the deceased alive on* Oct 14, 1967, *and that death occurred at* 6:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Roy D. Shaw M.D. 466		676 Shoup Ave W. Twin Falls Idaho	10/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 18, 1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10/23/67	Pamela J. Johnson	Jim A Hopkins	E-482

FIRM NAME: Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4670
Local Reg. No. D-363
Reg. Dist. No. 460

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 420 .000
b. CITY OR TOWN (If outside corporate limits, write [illegible] give township) Kimberly
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt.View Nursing Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Kimberly
d. STREET ADDRESS (If rural, give location) R.R.#1

3. NAME OF DECEASED (Type or Print)
a. (First) DANIEL
b. (Middle) H.
c. (Last) BATY

4. DATE OF DEATH (Month) (Day) (Year) October 15,1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH December 6,1886
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) St.James,Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Karl Baty — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Tilda Hughes — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-12-7442
17. INFORMANT'S OWN SIGNATURE Don Baty — ADDRESS Kimberly,Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Sclerosis generalized 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. *,* 1961 *, to* 10/15/ *,* 19 67 *, that I last saw the deceased alive on* 10-15 *,* 19 67 *, and that death occurred at* 9:15p. *m., from the causes and on the date stated above.*

23a. SIGNATURE T. Ellis King at Mt. 286 (Degree or title) M.D.
23b. ADDRESS Kimberly,Idaho
23c. DATE SIGNED 10-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/19/67
24c. NAME OF CEMETERY OR CREMATORY Rock Creek Cemetery
24d. LOCATION (City, town, or county) (State) Rock Creek,Idaho

DATE REC'D BY LOCAL REG. 10-19-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Paul D.Reynolds — LICENSE NO. E-495

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4671
Local Reg. No. D-367
Reg. Dist. No. 420

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420 — 139
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hansen — LENGTH OF STAY (in this place): 39 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 120 1st St. West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hansen
d. STREET ADDRESS (If rural, give location): 120 1st St. West

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NORA	BLISS	MARLIN	Oct. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
female	white	widowed 2	Feb. 27, 1881	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William T. Hill — BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Mary Jane Anderson — BIRTHPLACE: Ark.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - --- - - -
16. SOCIAL SECURITY NO.: 518-30-3052
17. INFORMANT'S OWN SIGNATURE: Mrs Helen Reynolds — ADDRESS: Hansen, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Myocardial Infarction
DUE TO (c): Coronary Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Investigation Only, 19—, *to* —, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 8 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
A. Thad Schlesselman 583 (Degree or title) Coroner 4	Twin Falls, Idaho	10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	10-19-67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10/23/67	Pamela J. Johnson	Dale P. Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-6502

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4672
Local Reg. No. D-366
Reg. Dist. No. 460

Certificate of Death

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 420 Twin Falls 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
c. LENGTH OF STAY (in this place): 3 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): HARRAL NURSING HOME 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): 927 Sprague Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): MARIE
b. (Middle): E.
c. (Last): CANOY

4. DATE OF DEATH (Month) (Day) (Year): Oct. 16, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 17, 1888
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Orangeville, Illinois
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rudy Bertalot — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME: May Engles — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-60-8977
17. INFORMANT'S OWN SIGNATURE: George D. Canoy — ADDRESS: 2036 Osterloh Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4200 ~~Perforated Gastric ulcer~~ Heart Failure Auto Arterio-sclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 2-3 wks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* ~~General Peritonitis~~ Severe Arthritis with marked Kyphosis — No. of years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-10, 1967, *to* 10-16, 1967 *that I last saw the deceased alive on* 10-15, 1967, *and that death occurred at* 2:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Vern H Anderson MD 011
23b. ADDRESS: Buhl, Ida
23c. DATE SIGNED: 10-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/19/67
24c. NAME OF CEMETERY OR CREMATORY: Buhl
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 10/23/67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: George Faomer
LICENSE NO.: E-480

Federal Security Agency
United States Public Health Service
Form DH-62021
FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17: to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4673
Local Reg. No. D-370
Reg. Dist. No. 460

BIRTH NO. 67-7240

Certificate of Death

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LEN. OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. Magic Valley Hosp. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 166 Carney St. 83301

3. NAME OF DECEASED (Type or Print)
a. (First) Sheila
b. (Middle) Diane
c. (Last) Huse

4. DATE OF DEATH (Month) (Day) (Year) October 17, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH August 10, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 2 Days 7 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leonard Zengenbein
BIRTHPLACE Unk.
14. MOTHER'S MAIDEN NAME Glenda Huse
BIRTHPLACE Twin Falls, Idah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE *Glenda Huse
ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7630

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) acute sepsis with pneumonitis (Dead on arrival) — INTERVAL BETWEEN ONSET AND DEATH 10 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/10/67, 1967, *to* 10/17, 1967, *that I last saw the deceased alive on* 10/8, 1967, *and that death occurred at* 10:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE S. M. Myers, MD 576 (Degree or title)
23b. ADDRESS 676 Shoshone Ave W Twin Falls Idaho
23c. DATE SIGNED 10/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Sunset
24b. DATE Oct 20, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10-24-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. E-343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary 833-6600

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4674
Local Reg. No. D-364
Reg. Dist. No. 46

Certificate of Death

STATE OF IDAHO

RECEIVED

OCT 26 1967

Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 42/TWIN FALLS 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TWIN FALLS
STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hospital 44

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 42 b. COUNTY TWIN FALLS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TWIN FALLS 83301
d. STREET ADDRESS (If rural, give location) Just-A-Mere Inn 2nd St. No.

3. NAME OF DECEASED (Type or Print) a. (First) NELLIE b. (Middle) M. c. (Last) BARNES

4. DATE OF DEATH (Month) (Day) (Year) Oct. 19, 1967

5. SEX female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married

8. DATE OF BIRTH Sept. 5, 1889

9. AGE (In years last birthday) 78 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY Housekeeping

11. BIRTHPLACE (State or foreign country) Bedford, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joe Barnes — BIRTHPLACE Unk.

14. MOTHER'S MAIDEN NAME Unk. — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-36-8739A

17. INFORMANT'S OWN SIGNATURE Mrs. Paul Bancroft — ADDRESS Shoshone

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Gallbladder. — INTERVAL BETWEEN ONSET AND DEATH 9-28-67

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cholelithiasis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Anemia - nutritional — 1 mo.

19a. DATE OF OPERATION 9-28-67

19b. MAJOR FINDINGS OF OPERATION Carcinoma Gallbladder, - inoperable

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-28, 1967, *to* 10-19-, 1967, *that I last saw the deceased alive on* 10-19, 1967, *and that death occurred at* 8:15 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Geary W. Warner MD

23b. ADDRESS 111 6th Ave East T.F.

23c. DATE SIGNED 10-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Removal

24b. DATE 10/21/1967

24c. NAME OF CEMETERY OR CREMATORY Bedford Cemetery

24d. LOCATION (City, town, or county) Bedford, Iowa (State)

DATE REC'D BY LOCAL REG. 10/23/67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER

LICENSE NO. E-343

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4675
Local Reg. No. D-369
Reg. Dist. No. 460

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 42 / Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 42 / Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 429 2nd Ave. West

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ellis	E.	Crabtree	October 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Sept. 9, 1875	92		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Minister 18	Pastor	Wytheville, Virginia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Crabtree	Va.	Agnes	Va.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-44-2180A	Mrs. E. E. Crabtree	Twin Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis c rt hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 23 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis Hemodyn. - years
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

332X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept 27, 1967, *to* Oct 19, 1967, *that I last saw the deceased alive on* Oct. 19, 1967, *and that death occurred at* 10:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Edward Rees MD 431	Twin Falls	10-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 23, 1967	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10/24/67	Pamela J. Johnson		E-343

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service
Form DH-62021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DCI 27 1967

APR 19 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4676
Local Reg. No. D-394
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) West Birch St

3. NAME OF DECEASED (Type or Print) a. (First) ALMA b. (Middle) L. c. (Last) BROWN

4. DATE OF DEATH (Month) Oct (Day) 20 (Year) 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH July 15, 1899
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Corpus Christi, Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME C.C. Holcomb — BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Rosa May Cook — BIRTHPLACE Texas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 450-18-2924
17. INFORMANT'S OWN SIGNATURE Frank Brown — ADDRESS R. 3 W. Birch St

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Infarction of Myocardium due to Coronary Sclerosis — INTERVAL BETWEEN ONSET AND DEATH 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____ 19__, to* Oct 20, 1967, *that I last saw the deceased alive on* Oct 19, 1967, *and that death occurred at* about 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Vern H Anderson, MD 011 (Degree or title)
23b. ADDRESS Buhl, Ida
23c. DATE SIGNED 11-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct 24, 1967
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. 11-16-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER George Farmer
LICENSE NO. E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME Albertson - Dickard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 3 1969

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4677
Local Reg. No. D-371
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
OCT 26 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
DURATION OF STAY (in this place) 1 Hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270 b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hazelton 83335
d. STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print) a. (First) JOE b. (Middle) C. c. (Last) GIBBS

4. DATE OF DEATH (Month) (Day) (Year) Oct. 21, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH June 11, 1923

9. AGE (In years last birthday) 44 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) self-employed 11

10b. KIND OF BUSINESS OR INDUSTRY gen'l. contractor

11. BIRTHPLACE (State or foreign country) No. Platte, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Byron J. Gibbs BIRTHPLACE Arkansas

14. MOTHER'S MAIDEN NAME Ida Mitchell BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW II 4

16. SOCIAL SECURITY NO. 518-22-7044

17. INFORMANT'S OWN SIGNATURE X Mrs. Helen C. Gibbs ADDRESS Hazelton

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Occlusion — 1½ hr.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/2, 1967, *to* 10/21, 1967, *that I last saw the deceased alive on* 10/21, 1967, *and that death occurred at* 10:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Roy O. Shaub M.D. 466 (Degree or title) 1

23b. ADDRESS 676 Shoup Ave W. T.F. Ida

23c. DATE SIGNED 10/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/25/1967

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. 10-24-67

REGISTRAR'S SIGNATURE Pamela L. Johnson

25. EMBALMER Wayne Tuller LICENSE NO. E-343

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4678
Local Reg. No. D-373
Reg. Dist. No. 460

RECEIVED OCT 30 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42 / Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of ...) Twin Falls
c. LENGTH OF STAY IN ... (This place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 561 5th Avenue North

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42 / T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 561 5th Avenue North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FERN		ELDRED	October 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	November 30, 1894	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		New Virginia, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Michael B. Cellman	Iowa	Harriett Foster	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-14-7581	Per G R Eldred	Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7220

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: ----

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease 10 yrs.
DUE TO (c) Rheumatic Arthritis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov., 1964, *to* 10/22/, 19 67, *that I last saw the deceased alive on* 10/22, 1967, *and that death occurred at* 8:50a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. Ellis Knight 286 M.D.	Kimberly, Idaho	10-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/25/67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-26-67	Pamela J. Johnson	Paul D. Reynolds	E495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4679
Local Reg. No. D-377
Reg. Dist. No. 460

RECEIVED NOV 3 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 309 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 604 11 Ave. North

3. NAME OF DECEASED (Type or Print) a. (First) Jerry b. (Middle) 143 E. c. (Last) Armstrong

4. DATE OF DEATH (Month) (Day) (Year) Oct. 22, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH June 28, 1885

9. AGE (In years last birthday) 82 If UNDER 1 YEAR Months Days If UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Boiler Fireman 27

10b. KIND OF BUSINESS OR INDUSTRY Food Processing

11. BIRTHPLACE (State or foreign country) Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jobe Armstrong BIRTHPLACE Ohio

14. MOTHER'S MAIDEN NAME Ida Gilbert BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-01-1935

17. INFORMANT'S OWN SIGNATURE K Golda Armstrong ADDRESS Buhl, Ida. 83316

18. CAUSE OF DEATH 4281
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Perforation of left ventricle of heart — INTERVAL BETWEEN ONSET AND DEATH 15 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary Thrombosis — 10 days

DUE TO (c) Arteriosclerosis — 10+5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 2 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 10, 1967, to Oct 22, 1967, *that I last saw the deceased alive on* Oct 22, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Vern Henderson MD (Degree or title)

23b. ADDRESS Buhl, Idaho

23c. DATE SIGNED 10-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 25, 1967

24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery

24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. 10-30-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Jim A Hopkins

LICENSE NO. E-482

FIRM NAME: Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service

Form DH-62021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 27 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

MAR 31 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4680
Local Reg. No. D-374
Reg. Dist. No. 460

RECEIVED
OCT 30 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Twin Falls 421 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp. 413

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 400

b. COUNTY: T.Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly

d. STREET ADDRESS (If rural, give location): Mt.View Nursing Home

3. NAME OF DECEASED (Type or Print): a. (First) OLLIE b. (Middle) c. (Last) HAMM

4. DATE OF DEATH (Month) (Day) (Year): October 23,1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: January 3,1884

9. AGE (In years last birthday): 83 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Piney Creek,North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Julius Smith BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Mary Rebecca Williams BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 518-60-9133

17. INFORMANT'S OWN SIGNATURE: X Emma Spence ADDRESS: Twin Falls,Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

5703

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Uremia — 2 weeks

DUE TO (c) Volvulus of small intestine — 4 weeks

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Gen. Arteriosclerosis — 5 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-30-60, 19____, *to* 10/23/, 1967, *that I last saw the deceased alive on* 10-23-67, 19____, *and that death occurred at* 10:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: W H Clark MD (Degree or title) M.D.

23b. ADDRESS: Twin Falls,Idaho

23c. DATE SIGNED: 10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/26/67

24c. NAME OF CEMETERY OR CREMATORY: I.O.O.F.Cemetery

24d. LOCATION (City, town, or county) (State): Filer,Idaho

DATE REC'D BY LOCAL REG.: 10-26-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Paul D.Reynolds — LICENSE NO.: E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form OH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4681
Local Reg. No. D-372
Reg. Dist. No. 460

RECEIVED
OCT 30 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Twin Falls 421 304

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301

LENGTH OF STAY (in this place): 4 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hosp 343

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Twin Falls 421

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301

d. STREET ADDRESS (If rural, give location): 332 Third Avenue West

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	HARRY	A.	PAWSON	October 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Divorced 4	Nov. 3, 1891	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Carpenter 71	Contracting	Archer, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Pawson	not known	not known	not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	World War 1	518-09-9008	Pauline Griffin	Twin Falls Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) Arteriosclerotic heart disease — 5 yrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Uremia due to benign prostatic hypertrophy and cardiac decompensation

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-4-67, 19__, *to* 10-23-67, 19__, *that I last saw the deceased alive on* 10-23-67, 19__ *and that death occurred at* 12:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. H. Clark M.D.	Twin Falls, Idaho	10-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-25-67	Twin Falls Cemetery	Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-25-67	Pamela L. Johnson	William J. Boyd	E-490

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Twin Falls Mortuary

DUTIES:

OCT 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 11 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4682
Local Reg. No. D-379
Reg. Dist. No. 460

NOV 3 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 080
b. CITY OR TOWN Twin Falls
(If outside corporate limits, write RURAL and give township)
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 443

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls Rural 83301
d. STREET ADDRESS (If rural, give location) Rural S. West of City

3. NAME OF DECEASED (Type or Print)
a. (First) LOUIS b. (Middle) J. c. (Last) TENCKINCK

4. DATE OF DEATH (Month) (Day) (Year) October 24, 1967

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH March 18, 1892

9. AGE (In years last birthday) 75
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Michigan

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Louis J. Tenckinck
BIRTHPLACE Holland

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-40-9215

17. INFORMANT'S OWN SIGNATURE [signature] ADDRESS Mrs. George VanTilburg by Hugh U. Philli

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 4 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pneumonia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

493X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1958, *to* Oct 24, 1967, *that I last saw the deceased alive on* Oct 24, 1967, *and that death occurred at* 10:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] MD (Degree or title)

23b. ADDRESS Twin Falls, Ida

23c. DATE SIGNED Oct 26 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10-31-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER [signature] LICENSE NO. E-343

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 9 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 27 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 16 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4683
Local Reg. No. 0-389
Reg. Dist. No. 460

RECEIVED NOV 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 (006)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Filer
d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print): a. (First) EMMA b. (Middle) c. (Last) Mc KINLEY

4. DATE OF DEATH: (Month) Oct (Day) 26 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 3	Feb 7, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01		Lewiston, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Blass	Illinois	Freda Rhorman	Yugoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-09-5745	Mrs Russell Lewis	Buhl

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) due to Carcinoma of Breast — Months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 6, 1962 *to* Oct. 25, 1967, *that I last saw the deceased alive on* Oct. 24, 1967, *and that death occurred at* 5:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D.	122 9th Ave No. Buhl	10-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Oct 28, 1967	Filer I.O.O.F. Cemetery	Filer Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-8-67	Pamela J. Johnson	George Farmer	E-480

ALTERNATE NAME: Dickard Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-6-6021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4684
Local Reg. No. D-378
Reg. Dist. No. 460

RECEIVED NOV 3 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 420
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
c. LENGTH OF STAY (in this place): 880
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mt. View Conval. Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 11th Ave East

3. NAME OF DECEASED (Type or Print): a. (First) NANCY b. (Middle) ELIZABETH c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year): October 26, 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widow 2

8. DATE OF BIRTH: September 4, 1870

9. AGE (In years last birthday): 97
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: John W. Stanley
BIRTHPLACE: Ky

14. MOTHER'S MAIDEN NAME: Nancy Cox
BIRTHPLACE: Ky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 518-54-1428

17. INFORMANT'S OWN SIGNATURE: Miles J. Browning
ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: ----

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Scleotic heart disease — 20 yrs.
DUE TO (c) Generalized arteriosclerosis — 20 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Oct. 26, 1967, *that I last saw the deceased alive on* Oct. 20 1967, *and that death occurred at* 2 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: Ellis Knight 286 (Degree or title) M.D.

23b. ADDRESS: Kimberly, Idaho

23c. DATE SIGNED: 10.27.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10.28.67

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park Cem.

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 10-31-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: [signature]
LICENSE NO.: 343
FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-62021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4685
Local Reg. No. D-383
Reg. Dist. No. 460

Certificate of Death

RECEIVED NOV 9 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 311
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 240 Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerman
d. STREET ADDRESS (If rural, give location) R.F.D. # 1

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPH
b. (Middle) LEON
c. (Last) OLLIVIER

4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH February 15, 1888
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Merchant 22
10b. KIND OF BUSINESS OR INDUSTRY Retail
11. BIRTHPLACE (State or foreign country) France
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Leon Ollivier — BIRTHPLACE France
14. MOTHER'S MAIDEN NAME Amelie Vacher — BIRTHPLACE France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 520-34-1755
17. INFORMANT'S OWN SIGNATURE Mrs Rose Ollivier — ADDRESS RFD RFD # 1 Hagerman, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Prostate with Extensive Bone Metastases — INTERVAL BETWEEN ONSET AND DEATH 6 mons

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Marked secondary Anemia — 2 mons

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar 1, 1967, *to* Oct 27, 1967, *that I last saw the deceased alive on* 10-27-, 1967, *and that death occurred at* 3:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Vern H Anderson, M.D. — 011 (Degree or title)
23b. ADDRESS Buhl, Idaho
23c. DATE SIGNED 11/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 10/30/67
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State) Provo, Utah

DATE REC'D BY LOCAL REG. 11-3-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER George Farmer
LICENSE NO. E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 29 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 17 1968

MAY 2 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4686
Local Reg. No. D-380
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 3 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 111 Sidney 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 111 Sidney

3. NAME OF DECEASED (Type or Print) a. (First) CLURE b. (Middle) D. c. (Last) HALL
4. DATE OF DEATH (Month) (Day) (Year) Oct. 27, 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH May 14, 1904
9. AGE (In years last birthday) 63 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Cab Driver 10
10b. KIND OF BUSINESS OR INDUSTRY Transportation
11. BIRTHPLACE (State or foreign country) Jamestown, No. Dakota
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Leota Hall
BIRTHPLACE Pa.
14. MOTHER'S MAIDEN NAME Etta Clure
BIRTHPLACE Minnesota
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) -----
16. SOCIAL SECURITY NO. 518-28-4664
17. INFORMANT'S OWN SIGNATURE Winifred R. Hall
ADDRESS Twin Falls, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary arteriosclerosis — 2 yrs.
DUE TO (c) Gen. Arteriosclerosis — 5 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 15 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-1-67, 19___, *to* 10-27-67, 19___, *that I last saw the deceased alive on* 10-27-67, 19___ *and that death occurred at* 10:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE W. H. Clark - M.D. 092 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 10-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 31, 1967
24c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 10-31-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER
LICENSE NO. E-343

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4687
Local Reg. No. D-382
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 427 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (in this place) 202 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazel Del Manor 289

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 427 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 1521 Poplar

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ALBERT	WARREN	SOWLE	October 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	April 21, 1873	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman 24	Automobile	Tomah, Wisconsin	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Warren Sowle	unknown	Annette unknown	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	519-09-7771	x Grace L. Sowle	Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Macrocytic anemia — Months

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 3-6-58, 19__, *to* 10-19, 1967, *that I last saw the deceased alive on* 10-19, 1967, *and that death occurred at* 4:15a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. W. Kendall M.D.	Twin Falls, Idaho	10-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-31-67	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-1-67	Pamela J. Johnson	William J. Boyd	E-490

FIRM NAME: Twin Falls Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4688
Local Reg. No. D-385
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 9 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 216.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 127 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics) Twin Falls
c. LENGTH OF STAY IN (This place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 340 Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) R.F.D. Heyburn
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Roy	Duvall	LaRue	October 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	March 23, 1894	73		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Retired	Holdredge, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William S. LaRue	unknown	Mary Malinda Gee	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes W.W.I 3	518-42-6275-A	Daisy M. LaRue	Heyburn Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rheumatic Heart Disease, With — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Tricuspid Insufficiency — 0
DUE TO (c) Pulmonary Edema, Chronic

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Chronic Ulcers of Stomach

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10/3, 1967, *to* 10/28, 1967, *that I last saw the deceased alive on* 10/27, 1967, *and that death occurred at* 7:15 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Roy V. Shaub M.D.	466	676 Shoup Ave W. Twin Falls Ida	11/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/1/67	Riverside	Heyburn Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-6-67	Pamela J. Johnson	Earl M. Lewis	E-460

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4689
Local Reg. No. D-376
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 3 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 8 Hours

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 820 8th Ave. North

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 408

3. NAME OF DECEASED (Type or Print)
a. (First) Roland
b. (Middle) H. 143
c. (Last) Kruckenberg

4. DATE OF DEATH (Month) (Day) (Year) Oct. 28, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Nov. 7, 1914
9. AGE (In years last birthday) 52 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Gardener & Custodian
10b. KIND OF BUSINESS OR INDUSTRY 06 Maintenance
11. BIRTHPLACE (State or foreign country) Lincoln, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Kruckenberg — BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Josephine Thaemert — BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 515-07-9963
17. INFORMANT'S OWN SIGNATURE X Renato Graesch — ADDRESS Buhl, Ida. 83316

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 8hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 5yrs+
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 27 Oct, 1967, *to* 28 Oct, 1967, *that I last saw the deceased alive on* 27 Oct, 1967, *and that death occurred at* 2:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE James H. Gafford 409 (Degree or title) M.D.
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 11/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 31, 1967
24c. NAME OF CEMETERY OR CREMATORY Clover Lutheran
24d. LOCATION (City, town, or county) Twin Falls County (State) Idaho

DATE REC'D BY LOCAL REG. 10-30-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER James A. Hopkins
LICENSE NO. E-482
FIRM NAME: Buhl Funeral Chapel 83316

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4690
Local Reg. No. D-386
Reg. Dist. No. 460

RECEIVED NOV 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42/Twin Falls 417
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 17 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosital 413

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 359 Harrison

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Dora	G	Fowles	Oct.	30	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Femele	White	Widowed 2	Oct. 26 1873	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House Wife 01	retired	Hooper, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nelson Grove	Canada	Arline Wadsworth -	Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	528-28-3591	Nora G. Hamilton	Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastro-intestinal Hemmorhage — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis — 6 years
DUE TO (c) Fracture of Hip — 4 Weeks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 4-19, 1967, *to* 10-30, 1967, *that I last saw the deceased alive on* 10-29, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
578	Twin Falls, Idaho 83301	11-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	10/30/67	Pleasant View	Burley, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-6-67	Pamela J. Johnson		E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4691
Local Reg. No. 10-381
Reg. Dist. No. 460

Certificate of Death

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
d. STREET ADDRESS (If rural, give location) 627 Main St.

3. NAME OF DECEASED (Type or Print)
a. (First) WHEELER
b. (Middle) W.
c. (Last) ELLEDGE

4. DATE OF DEATH (Month) (Day) (Year) Oct. 30, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Feb. 8, 1877
9. AGE (In years last birthday) 90 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) postmaster 08
10b. KIND OF BUSINESS OR INDUSTRY U.S.GOVT.
11. BIRTHPLACE (State or foreign country) Hays, North Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph P. Elledge — BIRTHPLACE No. Carolina
14. MOTHER'S MAIDEN NAME Paulina Hays — BIRTHPLACE No. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. 528-28-2863
17. INFORMANT'S OWN SIGNATURE Filer, Idaho — ADDRESS x Blanche K. Elledge

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Urinary Retention — INTERVAL BETWEEN ONSET AND DEATH 24 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Urethral Abscess — unknown
DUE TO (c) Adenocarcinoma of Prostate gland — 3 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Septicemia

19a. DATE OF OPERATION 10/29/67
19b. MAJOR FINDINGS OF OPERATION Urethral Abscess and Adenocarcinoma of Prostate gland
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/29, 1967, *to* 10/29, 1967, *that I last saw the deceased alive on* 10/30, 1967, *and that death occurred at* 2:20a *m., from the causes and on the date stated above.*

23a. SIGNATURE George T Davis MD 132 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 10/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 11-2-67
24c. NAME OF CEMETERY OR CREMATORY Central Cemetery
24d. LOCATION (City, town, or county) (State) Central, Idaho

DATE REC'D BY LOCAL REG. 11-1-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Dale P. Patterson — LICENSE NO. E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4692
Local Reg. No. 38
Reg. Dist. No. 316

RECEI

Certificate of Death

STATE OF IDAHO

BIRTH NO.

OCT 30 1967

Bureau of Vital Sta.

1. PLACE OF DEATH

a. COUNTY 430 Valley 427

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall

c. LENGTH OF STAY (in this place) 27 Hrs

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley Memorial Hospital ~~752~~ 207

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 250 b. COUNTY Idaho

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville

d. STREET ADDRESS (If rural, give location) Rt # 2 Box 104

3. NAME OF DECEASED (Type or Print)

a. (First) GUY b. (Middle) KING c. (Last) RUSSELL

4. DATE OF DEATH (Month) (Day) (Year) September 30, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH February 5, 1894

9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Enterprise, Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Russell — BIRTHPLACE San Francisco, Calif

14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 14 5365

17. INFORMANT'S OWN SIGNATURE Georgia DeHaas — ADDRESS Grangeville, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

525X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH 48h.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Chronic obstructive lung Disease — 20 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Congestive heart failure 2° Arteriosclerotic heart Disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-29, 1967, *to* 9-30, 1967, *that I last saw the deceased alive on* 9-30, 1967, *and that death occurred at* 1:30 pm., *from the causes and on the date stated above.*

23a. SIGNATURE Wayne F. Allen MD 006 (Degree or title)

23b. ADDRESS McCall, Idaho

23c. DATE SIGNED 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10/3/1967

24c. NAME OF CEMETERY OR CREMATORY Prairieview

24d. LOCATION (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. Oct 26 1967

REGISTRAR'S SIGNATURE Myrtle M Gardner

25. EMBALMER Burton C Walker

LICENSE NO. E-386

Federal Security Agency
United States Public Health Service

Form DH-6902

FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
OCT 18 1967
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4693
Local Reg. No. 96
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Valley 430 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Chief Cafe 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 438
b. COUNTY: Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cascade
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ARCHIE	E.	MC NEIL	October 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	never married	May 18, 1901	66		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mill worker 170	Boise Cascade Corp	Round Valley, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Albert Mc Neil	Canada	Lottie Lathrop	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-34-3741	Mrs. Lottie Oliver	Cascade, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAN INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 HRS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		CASCADE VALLEY IDA

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct, 1956, *to* Oct., 1967, *that I last saw the deceased alive on* Sept 6, 1967 *and that death occurred at* 11 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
John F. Moon 376 (Degree or title) M.D.	CASCADE, IDA	10/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 9, 1967	Alpha Cemetery	Valley County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct-16-1967	Myrtle M. Gardner	Burton C. Walker	E-386

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: WALKER FUNERAL HOME

DUTIES:

NOV 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 18 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4694
Local Reg. No. 27
Reg. Dist. No. 910

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Valley 430 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 430
b. COUNTY: Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MATT	EINO	PAANANEN	October 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Jan. 16. 1912	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mill worker - Boise Cascade Corp.	"	McCall, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Paananen	Finland	Mary Maki	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	90 days-1941 6	518-07-4976	Nelma Standish	McCall Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Status Asthmaticus — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchial asthma — 5 yrs+
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Apr 1955, *to* Oct 5, 1967, *that I last saw the deceased alive on* Oct 5, 1967, *and that death occurred at* 730A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
James F Stewart MD	McCall, Idaho	10-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Oct. 7, 1967	McCall Cemetery	McCall Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Oct-16-67	Myrtle A. Gardner	Burton C Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

OCT 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4695
Local Reg. No. 39
Reg. Dist. No. 310

BIRTH NO. 67-10341 RECEIVED OCT 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY Valley 430 406
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (in this place) 6 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 430
b. COUNTY Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) BABY GIRL
b. (Middle)
c. (Last) VALDEZ

4. DATE OF DEATH (Month) (Day) (Year) October 16, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) infant 1
8. DATE OF BIRTH October 16, 1967
9. AGE (In years last birthday) If under 1 year: Months / Days; If under 24 hrs.: Hours 6 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) McCall, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Gordon Valdez
BIRTHPLACE Salt Lake City, Utah
14. MOTHER'S MAIDEN NAME Donna Earl
BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Gordon L. Valdez ADDRESS McCall, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7735

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 6h.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Respiratory distress syndrome — 4h.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-16, 1967, *to* 10-16, 1967, *that I last saw the deceased alive on* 10-16, 1967, *and that death occurred at* 7:00 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE Wayne F. Allen 006 (Degree or title) 1
23b. ADDRESS McCall Idaho
23c. DATE SIGNED 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY McCall Cemetery
24d. LOCATION (City, town, or county) McCall, (State) Idaho

DATE REC'D BY LOCAL REG. Oct 26 1967
REGISTRAR'S SIGNATURE Myrtle M. Gardner
25. EMBALMER Burton E. Walker
LICENSE NO. E-386

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-10347 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4696
Local Reg. No. 40
Reg. Dist. No. 310

BIRTH NO.

OCT 30 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Valley 430 406
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
LENGTH OF STAY (In this place): 6 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 430
b. COUNTY: Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) BABY BOY b. (Middle) c. (Last) VALDEZ

4. DATE OF DEATH: October 16, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): infant

8. DATE OF BIRTH: October 16, 1967

9. AGE (In years last birthday): If under 1 year: Months / Days; If under 24 hrs.: Hours 6 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): McCall, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Gordon Valdez — BIRTHPLACE: Salt Lake City, Utah

14. MOTHER'S MAIDEN NAME: Donna Earl — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Gordon L. Valdez — ADDRESS: McCall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7735

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Respiratory distress syndrome — INTERVAL BETWEEN ONSET AND DEATH: 3h.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Prematurity (6mo. gestation) — 5h.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-16, 1967, *to* 10-16, 1967, *that I last saw the deceased alive on* 10-16, 1967, *and that death occurred at* 6:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wayne F. Allen M.D. (Degree or title)
23b. ADDRESS: McCall Idaho
23c. DATE SIGNED: 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: October 22, '67
24c. NAME OF CEMETERY OR CREMATORY: McCall Cemetery
24d. LOCATION (City, town, or county) (State): McCall, Idaho

DATE REC'D BY LOCAL REG.: Oct 26 1967
REGISTRAR'S SIGNATURE: Myrtle M. Gardner
25. EMBALMER: Burton E. Walker
LICENSE NO.: E-386

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: WALKER FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED OCT 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4697
Local Reg. No. 47
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Valley 430 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 430
b. COUNTY: Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) VERA b. (Middle) JANICE c. (Last) PAANANEN

4. DATE OF DEATH: (Month) October (Day) 19, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: July 26, 1905

9. AGE (In years last birthday): 63 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 07

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kellogg, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ross Conner — BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Vergie Thompson — BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-14-8446

17. INFORMANT'S OWN SIGNATURE: x Jane Bell — ADDRESS: Swiss Home, Oregon

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Acute myocardial infarction	2 wks
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic heart disease	10 yrs+
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Essential Hypertension	10 yrs+

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour):

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Apr, 1957, *to* Oct 19, 1967, *that I last saw the deceased alive on* Oct 19, 1967, *and that death occurred at* 1 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James H Stewart MD — **23b. ADDRESS**: McCall Idaho — **23c. DATE SIGNED**: 10-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Octo22, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: McCall Cemetery — **24d. LOCATION** (City, town, or county) (State): McCall, Idaho

DATE REC'D BY LOCAL REG.: Oct 25-1967 — REGISTRAR'S SIGNATURE: Maydie McGardner

25. EMBALMER: Burton E Walker — LICENSE NO.: E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

OCT 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician She had previous myocardial infarctions '58 + '64.

State File No. 4698
Local Reg. No. 42
Reg. Dist. No. 310

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 9 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley County
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 430
b. COUNTY Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print)
a. (First) ANNA
b. (Middle) MAY
c. (Last) HUFFMAN

4. DATE OF DEATH (Month) Oct. (Day) 23 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Aug.8,1884
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister 18
10b. KIND OF BUSINESS OR INDUSTRY Missionary Baptist
11. BIRTHPLACE (State or foreign country) Paris, Illinois
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Squire Chastian — BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME Anna Kauffman — BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Georgia E. Kiser — ADDRESS Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) generalized arteriosclerosis
DUE TO (c) diabetes mellitus

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 66, *to* 10/23/67, 19__, *that I last saw the deceased alive on* 10/23/67, 19__, *and that death occurred at* 5:38a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 391 Harold S Nokes M.D. (Degree or title)
23b. ADDRESS McCall, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Oct.23,1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. Nov 1-1967
REGISTRAR'S SIGNATURE Myrtle M. Gardner
25. EMBALMER Marshall S Dickerson Jr. — LICENSE NO. E-464
FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4699
Local Reg. No. 26
Reg. Dist. No. 320

RECEIVED OCT 23 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 44 Washington 000
b. CITY OR TOWN Weiser (If outside corporate limits, write RURAL and give township) — STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Weiser Memorial Hospital 53

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 48 — b. COUNTY Washington
c. CITY OR TOWN Cambridge
d. STREET ADDRESS (If rural, give location) ---

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	FLOYD	ALVA	BURGESS		10	4	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married	11/26/1898	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Troy, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edwin Burgess	----	Ella May Park	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWII 4		Walter E. Ford	Nyssa, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ca. Left Ureter
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-28-, 1967, *to* 10-4-, 1967, *that I last saw the deceased alive on* 10-4-, 1967, *and that death occurred at* 2:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.D. McGuath M.D. 3414	Weiser, Idaho	10/4/1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10/9/1967	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10/4/1967	L. Dale Thomason	Marshall S. Dickerson Jr.	E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 30 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4700
Local Reg. No. 28
Reg. Dist. No. 320

Certificate of Death

STATE OF IDAHO

RECEIVED OCT 30 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 441
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) Rt. 3

3. NAME OF DECEASED (Type or Print)
a. (First) JAMES
b. (Middle) ELLIS
c. (Last) SMITH

4. DATE OF DEATH (Month) Oct. (Day) 18 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 27, 1909
9. AGE (In years last birthday) 57 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Logan, Utah
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Alfred C. Smith — BIRTHPLACE Logan, Utah
14. MOTHER'S MAIDEN NAME Mary Ellis — BIRTHPLACE Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-16-5007
17. INFORMANT'S OWN SIGNATURE Jennie B. Smith — ADDRESS Rt.3, Weiser, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5928

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary congestion — INTERVAL BETWEEN ONSET AND DEATH: 8 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Acute uremia — 2 wks
DUE TO (c) Chr. glomerulonephritis — unk.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/5, 1967, *to* 10/18, 1967, *that I last saw the deceased alive on* 10/17, 1967, *and that death occurred at* 12:43 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 186 (Degree or title)
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED Oct.18,1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct.21,1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. Oct.18,1967
REGISTRAR'S SIGNATURE R. Dave Thomason
25. EMBALMER Marshall S. Dickerson Jr.
LICENSE NO. E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 9 1978

AUG - 9 1994

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4701
Local Reg. No. 30
Reg. Dist. No. 320

RECEIVED
NOV 2 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington
b. CITY OR TOWN Weiser
(If outside corporate limits, write RURAL and give township)
LENGTH OF STAY (in this place) 600
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Idaho
b. COUNTY Washington 447
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 53 ----

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	JOE		CRAWFORD

4. DATE OF DEATH: (Month) Oct. (Day) 20 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Jan. 29, 1892	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer & Logger 04	Farm & Logging	Roxton, Texas	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
E. J. Crawford	----	----	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	519-16-6845	Vera Perrigo	Weiser, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1637

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma - lung — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 8-25-67, 19____, *to* 10-20-67, 19____, *that I last saw the deceased alive on* 10-20-67, 19____, *and that death occurred at* 5:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas R. McDonnell, M. D. 667	Weiser, Idaho	Oct. 20, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Removal-Burial	Oct. 23, 1967	Emmett Cemetery	Emmett	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-23-67	R. Dale Passmore	Marshall S. Dickenson	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: NOV 3 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4702
Local Reg. No. 29
Reg. Dist. No. 320

RECEIVED
OCT 30 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 440 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cambridge
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ---- 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 440
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cambridge
d. STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print)
a. (First) LEILA
b. (Middle) ESTELLE
c. (Last) KINNEY

4. DATE OF DEATH (Month) Oct. (Day) 23 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) wodowed 2
8. DATE OF BIRTH Feb.16, 1886
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Pendleton, Oregon
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME William E. Roper — BIRTHPLACE ---
14. MOTHER'S MAIDEN NAME Flora McCay — BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Richard W Kinney — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Backing car hit and ran over subject, crushing chest.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: seconds

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 440 **(STATE)** Cambridge, Washington Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 10-23-67 11a m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? car backed over crushing chest of subject.

22. *I hereby certify that I attended the deceased from* Coroner Investigation *, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 11 *m., from the causes and on the date stated above.*

23a. SIGNATURE R. Dale Thomason — 583 (Degree or title) Wash. Co. Coroner 4
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED Oct.23/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE Oct.26,1967
24c. NAME OF CEMETERY OR CREMATORY Cambridge Cemetery
24d. LOCATION (City, town, or county) Cambridge (State) Idaho

DATE REC'D BY LOCAL REG. 10-23-67
REGISTRAR'S SIGNATURE R. Dale Thomason
25. EMBALMER R. Dale Thomason
LICENSE NO. E 388

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 31 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 2 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4703
Local Reg. No. 31
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 041 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 041 Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) B. c. (Last) MCANARNEY

4. DATE OF DEATH (Month) Oct. (Day) 23 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Feb. 4, 1894

9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (State or foreign country) Venice, Illinois

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME ---- BIRTHPLACE ----

14. MOTHER'S MAIDEN NAME ---- BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE + Lucille M. Greer ADDRESS Weiser

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Coronary Occl. — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerot. - H.D. — 5y
DUE TO (c) Gen. Arteriosclerosis — 20y

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic Brain Syndrome

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/3, 19 65, *to* 10/23, 19 67, *that I last saw the deceased alive on* 10/23, 19 67, *and that death occurred at* 2:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS Weiser, Idaho

23c. DATE SIGNED Oct. 23, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 25, 1967

24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery

24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. 10-23-67

REGISTRAR'S SIGNATURE R. Dee Thomas

25. EMBALMER Marshall Dickenson

LICENSE NO. E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED NOV 6 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4704
Local Reg. No. 32
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 440 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Rural Weiser
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Weiser 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 447 Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 611 E. Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	ROY	VIRGIL	ELLISON	Oct.	28	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 22, 1915	52				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wholesale Distributor 22	Wholesale	Roy, Missouri	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Kell Ellison	----	----	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
			Laurence N. Ellison	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subject died of an apparent heart attack while hunting. To the best of my knowledge and belief subject died of natural causes.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, *19*____, *to* _____, *19*____, *that I last saw the deceased alive on* _____, *19*____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Justice of the Peace 588		Weiser, Idaho	Oct. 28, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Bur. Removal	Nov. 1, 1967	Fairview Cemetery	Weiser, Rt. 3 Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
10-28-67	L. Dale Thomason	L. Dale Thomason	E-388

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 29 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4705
Local Reg. No. 624
Reg. Dist. No. 270

BIRTH NO. RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 01 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give) Boise — c. LENGTH OF STAY (in this place) 6 mos. — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Treasure Valley Manor Rest Home 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY 060 Bingham — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Aberdeen — d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
RALPH	A.	WORRELL	Oct.	28,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 22, 1892	74	11	6		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Onawa, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Worrell	Virginia	Pairlee Bohnam	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW1 3	519-01-3449A	Mrs. Ralph Worrell	Aberdeen, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Cor pulmonale	4-5 yrs
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Pulmonary emphysema	10 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Aug, 1966, *to* Oct 28, 1967, *that I last saw the deceased alive on* Oct 30, 1967, *and that death occurred at* 2:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. R. Blackburn M.D 0461	800 La Cassia Way	Nov 1867

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Rem. & Burial 3	11-1-67	Aberdeen Cemetery	Aberdeen, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-20-67	Myrtle Palmer	Howell Nielsen	E-509

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 21 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 4 1980

3. THE REGISTRAR can issue a burial or removal permit.ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4706
Local Reg. No. 645
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
d. STREET ADDRESS (If rural, give location) 1127 Meridian St.

3. NAME OF DECEASED (Type or Print)
a. (First) Clare
b. (Middle) R.
c. (Last) Bodine

4. DATE OF DEATH (Month) (Day) (Year) Oct. 30, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 6, 1895
9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner Bodine Oil Co. 22
10b. KIND OF BUSINESS OR INDUSTRY Oil and Gasoline
11. BIRTHPLACE (State or foreign country) Eagle Grove, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert Bodine — BIRTHPLACE Ill.
14. MOTHER'S MAIDEN NAME Anna Brood — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-09-0467
17. INFORMANT'S OWN SIGNATURE Lena R. Bodine — ADDRESS Meridian

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

578X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhagic necrosis of bowel — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chr. pulm. emphysema c̄ cor pulmonale ? years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 30 Oct, 1967, *to* 30 Oct, 1967, *that I last saw the deceased alive on* 30 Oct, 1967, *and that death occurred at* 8:10 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD 212 1
23b. ADDRESS 6003 Overland, Boise Ida.
23c. DATE SIGNED 20 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-2-67
24c. NAME OF CEMETERY OR CREMATORY Meridian Cemetery
24d. LOCATION (City, town, or county) (State) Meridian, Idaho

DATE REC'D BY LOCAL REG. 11-29-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Leo Jerread
LICENSE NO. E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

9

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 14 1967 Bureau of Vital Statistics

State File No. 4707
Local Reg. No. 611
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 3 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. LUKES HOSPITAL 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 142 CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
d. STREET ADDRESS (If rural, give location): 1003 6th STREET SOUTH

3. NAME OF DECEASED (Type or Print)
a. (First): RAY
b. (Middle): P.
c. (Last): CLAGUE

4. DATE OF DEATH (Month) (Day) (Year): NOV. 1, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: AUG. 6, 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REAL ESTATE SALES 24
10b. KIND OF BUSINESS OR INDUSTRY: THOMPSON REALTY
11. BIRTHPLACE (State or foreign country): HERMAN, MINN.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: PHILLIP CLAGUE — BIRTHPLACE: ENGLAND
14. MOTHER'S MAIDEN NAME: FAUSTINE PRESCOTT — BIRTHPLACE: MASS.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 506-03-3869
17. INFORMANT'S OWN SIGNATURE: Shirley C. Nicholson — ADDRESS: NAMPA

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 1810 metastatic brain tumor

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Primary malignant bladder (urinary) tumor
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/30/, 1967, *to* 11/1/67, 19__, *that I last saw the deceased alive on* 11/1/, 1967, *and that death occurred at* 4:00P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edward J. Strifer 281 M.D.
23b. ADDRESS: BOISE, IDAHO
23c. DATE SIGNED: 11/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 11-4-67
24c. NAME OF CEMETERY OR CREMATORY: CLOVERDALE MEMORIAL
24d. LOCATION (City, town, or county) (State): BOISE, IDAHO

DATE REC'D BY LOCAL REG.: 11-9-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHEPHERD MORTUARY

NOV 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4708
Local Reg. No. 609
Reg. Dist. No. 270

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 001 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print): a. (First) Margaret; b. (Middle) J.; c. (Last) Whitworth

4. DATE OF DEATH: (Month) Nov. (Day) 2, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Oct. 6, 1904

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Britton, South Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Walter C. Johnson
BIRTHPLACE: Mich.

14. MOTHER'S MAIDEN NAME: Sue Wallace
BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-54-8362

17. INFORMANT'S OWN SIGNATURE: Lennie Blair
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1750 Metastatic Carcinoma Ovary — INTERVAL BETWEEN ONSET AND DEATH: 2½ years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June, 1965, *to* Nov, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 7:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE: George R Bolen, MD 019 (Degree or title)
23b. ADDRESS: 121 East Idaho
23c. DATE SIGNED: 11/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-6-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 11-9-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Yes Jerred
LICENSE NO.: E. 386
FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 28 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4709
Local Reg. No. 607
Reg. Dist. No. 370

BIRTH NO.

NOV 6 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: ADA 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): RICE FORD GARAGE, BOISE, IDAHO 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: IDAHO

b. COUNTY: ADA 011

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): Route 3, Coleen Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DONALD	ELWIN	WEILER	NOVEMBER 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
MALE	WHITE	MARRIED 3	March 2, 1929	38		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 21	Auto Dealer	St. Joseph, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elwin Eugene Weiler	Nebraska	Alma Lee Boylan	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes 5/7/46 to 3/13/48	537-24-9074	X Mrs Lylura Weiler	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed Chest, Broken Neck. — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Machanic working under an Auto. Jack slipped out. Auto fell on him. Mins;

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 011	(COUNTY) 13	(STATE)
Accident	19	Boise	Ada	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
II I 67 430P 21	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Auto Fell on him. while working under it.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 430 PM., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
C. D. Faris 583 (Degree or title) Coroner 4	3720 Meadow Drive, Boise.	II-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Nov. 4, 1967	Morris Hill Cemetery	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-7-67	Myrtle Palmer	Conway Grant Conway Grant	E478

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: RELYEA MORTUARY

NOV 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4710
Local Reg. No. 172
Reg. Dist. No. 371

RECEIVED NOV 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA. 011 3-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE, Idaho.
c. LENGTH OF STAY (in this place): 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO.
b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise,
d. STREET ADDRESS (If rural, give location): Idaho State Soldiers Home.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Charles	C	DAVIS.		11	2	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Widowed. 2	11-9-86	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer. 04	Same	Kansas	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Davis.	I.ll.	Julie Holt.	Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
WW 1-Yes 3 Yes WW 1	518425608	John D Stark	VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

332.X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes mellitus — 4 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
VA m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. ~~I hereby certify that I~~ attended the deceased from 10-29, 19 67, to 11-2, 19 67, ~~last saw the deceased alive on~~ and that death occurred at 5:55AM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Glenn Voyles GLENN Q VOYLES, M.D. 544 1	VA Center, Boise, Idaho.	11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	November 4, 1967	Ft. Scott National Cemetery	Ft. Scott, Kansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-3-67	Myrtle Palmer	Eldon T. Pearson / Eldon T. Pearson	E-512

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4711
Local Reg. No. 176
Reg. Dist. No. 371

BIRTH NO.

RECEIVED NOV 9 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eagle Rural
c. LENGTH OF STAY (in this place) 2
d. FULL NAME OF HOSPITAL OR INSTITUTION 1½ Miles No. of 44 on 16 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
d. STREET ADDRESS (If rural, give location) 1505 W. 1st

3. NAME OF DECEASED (Type or Print) a. (First) Virgil b. (Middle) Dean c. (Last) Luke

4. DATE OF DEATH (Month) (Day) (Year) Nov. 2, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH June 30, 1929
9. AGE (In years last birthday) 38 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owned Dry Cleaning Plant
10b. KIND OF BUSINESS OR INDUSTRY 22
11. BIRTHPLACE (State or foreign country) King Hill, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Arthur Ray Luke BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Ella J. Sand BIRTHPLACE So. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-28-6854
17. INFORMANT'S OWN SIGNATURE Virginia L. Luke ADDRESS Meridian

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiply Head & Brain injury — INTERVAL BETWEEN ONSET AND DEATH Inst;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Lost Control of his Auto. skidded across Hiway, across a Dry Canal, Flipped end over end throwed out.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident,
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 000 (STATE)
21d. TIME OF INJURY (Month) II (Day) 2 (Year) 67 (Hour) 930A.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto Accident. Flipped end over end.

22. I hereby certify that I attended the deceased from Did Not See Alive, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at 9:30A. m., from the causes and on the date stated above.

23a. SIGNATURE 583 (Degree or title) Coroner
23b. ADDRESS 3720 Meadow Drive, Boise.
23c. DATE SIGNED II-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-4-67
24c. NAME OF CEMETERY OR CREMATORY Terrace Lawn
24d. LOCATION (City, town, or county) Meridian, Idaho (State)

DATE REC'D BY LOCAL REG. 11-9-67
REGISTRAR'S SIGNATURE Myrtle Palmer Deputy Registrar
25. EMBALMER
LICENSE NO. E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 9 1993

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4712
Local Reg. No. 180
Reg. Dist. No. 371

RECEIVED NOV 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA. 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho.
STAY (in this place): 38 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 2-01 411
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location): RT # 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Wilbur	NMI	WALDROP.		11	2	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married 1	9-24-88	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Forrest Service. 08	Same	Oregon.	USA.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jacob Waldrop.	Indiana	Ada Strader	Indiana.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1 3	519345051	John D. Waldrop	VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic pneumonia - bilateral. — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
a. Generalized arteriosclerotic disease. 5 yrs.
b. Fracture, right hip. 1 day

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
VA m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. I hereby certify that I attended the deceased from 9-25, 19 67, to 11-2, 19 67 and that death occurred at 2:15PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. G STROMBERG, M.D. 597	VA Center, Boise, Idaho	11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11-2-67		Weiser, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-10-67	Myrtle Palmer	Ira E. Walker	E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 20 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4713
Local Reg. No. 625
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Eagle
d. STREET ADDRESS (If rural, give location) Box 191

3. NAME OF DECEASED (Type or Print)
a. (First) HOMER
b. (Middle) A.
c. (Last) EDWARDS

4. DATE OF DEATH (Month) Nov. (Day) 3 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 7, 1895
9. AGE (In years last birthday) 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat packer-retired
10b. KIND OF BUSINESS OR INDUSTRY 21 Meat Packing
11. BIRTHPLACE (State or foreign country) Drayton, North Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Richard Edwards — BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Jessie Campbell — BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WWI 3
16. SOCIAL SECURITY NO. 518-36-2215
17. INFORMANT'S OWN SIGNATURE Alta Edwards — ADDRESS Box 191 Eagle, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured abdominal aneurysm — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Atherosclerotic abdominal aorta with aneurysm — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* chronic obstructive pulmonary emphysema — years

451X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 Nov, 1967, *to* 3 Nov, 1967, *that I last saw the deceased alive on* 3 Nov, 1967, *and that death occurred at* 5:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE J Hugh Atchley 014 (Degree or title) MD
23b. ADDRESS 401 Idaho St Boise Ida
23c. DATE SIGNED 16 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery
24d. LOCATION (City, town, or county) Boise / (State) Idaho

DATE REC'D BY LOCAL REG. 11-20-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Dowell D. Demaray
LICENSE NO. E 509

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 5 1967

DEC 19 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4714
Local Reg. No. 173
Reg. Dist. No. 371

Certificate of Death

RECEIVED NOV 6 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1816 No. 20th. St.

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle):
c. (Last): Plamondon

4. DATE OF DEATH (Month) (Day) (Year): Nov. 3, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 28, 1878
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Elkhorn, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Peter Plamondon — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Catherine Hatton — BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 396-07-2610
17. INFORMANT'S OWN SIGNATURE: x Mrs. Arlene Barnes — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*: Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): (Cerebral-Heart + Kidney)
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death*: Senility

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1964 *19*, *to* Nov 3, 1967, *that I last saw the deceased alive on* Nov 1 1967, *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): N M Chalaupka 088 M D
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 11/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/6/67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-6-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature] — LICENSE NO.: E-460

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McBratney-Alden-Waggoner

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4715
Local Reg. No. 668
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 — NOV 6 1967 — 000
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION: D.O.A. St. Luke's Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1002 E. Washington St.

3. NAME OF DECEASED (Type or Print): a. (First) Helen — b. (Middle) P. — c. (Last) Sandlin

4. DATE OF DEATH: (Month) Nov. (Day) 4, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Jan. 18, 1885

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harvey A. Hatcher — BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Louisiana Bell — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 519-58-9501

17. INFORMANT'S OWN SIGNATURE: X O L Hatcher — ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 4201 Acute Coronary — Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, 19—, to alive, 19—, *that I last saw the deceased alive on* 11-4, 1967, *and that death occurred at* — m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 318 (Degree or title)

23b. ADDRESS: 401 100 Orchard Boise Ida

23c. DATE SIGNED: 11/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-7-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-6-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature] — LICENSE NO.: E-460

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 9 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4716
Local Reg. No. 777
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 010 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 30 and Railroad Crossing 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): 428 E. State

3. NAME OF DECEASED (Type or Print)
a. (First): Jo Anne
b. (Middle):
c. (Last): Link

4. DATE OF DEATH (Month) (Day) (Year): Nov. 4, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: April 28, 1951
9. AGE (In years last birthday): 16 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 03 Student
10b. KIND OF BUSINESS OR INDUSTRY: Meridian High School
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph R. Link — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Delores Swan — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: J. R. Link — ADDRESS: Meridian

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8101

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiply Head & Brain Injury — INTERVAL BETWEEN ONSET AND DEATH: Inst;

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) [redacted], Body badly Mangled.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 10
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 000
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): II 4 67 143A 1
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Train & Auto Collision.

22. *I hereby certify that I attended the deceased from* Did Not See, *to* Alive, 19__, *that I last saw the deceased alive on* ____ 19__, *and that death occurred at* 1:43 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris 583 (Degree or title) Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: II-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 11-8-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-9-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: See Jerreal
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021 Helen Olson
FIRM NAME: Robison Chapel of the Chimes

NOV . 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED NOV 9 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4717
Local Reg. No. 178
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 010 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Highway 30 and Railroad crossing 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian Rural
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Gordon
b. (Middle): Eugene
c. (Last): Cooper

4. DATE OF DEATH (Month) (Day) (Year): Nov. 4, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: Aug. 5, 1947
9. AGE (In years last birthday): 20 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charlie Cooper — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Edith Shaul — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Charlie Cooper — ADDRESS: Rt. 1 Meridian

18. CAUSE OF DEATH 8101
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Multiply Head & Brain Injury — INTERVAL BETWEEN ONSET AND DEATH: Inst;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Body badly Mangled.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [ ] NO [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 10
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 000
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): II 4 67 143A m. 1
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Train & Auto Collision.

22. *I hereby certify that I attended the deceased from* Did Not See Alive *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 1:43A *m., from the causes and on the date stated above.*

23a. SIGNATURE: D. Paris 583 (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive. Boise.
23c. DATE SIGNED: II-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 11-8-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-9-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jerread
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021 Helen Olson
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 9 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4718
Local Reg. No. 175
Reg. Dist. No. 371

RECEIVED NOV 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 ADA 2-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE, IDAHO
c. LENGTH OF STAY (in this place) 123 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO. b. COUNTY 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) PAYETTE.
d. STREET ADDRESS (If rural, give location) 331 Nth 10th St

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Lwellyn	G	HEPWORTH		11	5	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	12-24-01	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Salesman Retired. 24	Same	Kansas	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lwellyn G Hepworth.	Mich.	Bertha B Wilson.	Ill

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 11 4	478 03 2915	John O Hepworth	VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

3561

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Amyotrophic lateral sclerosis. — INTERVAL BETWEEN ONSET AND DEATH: 8 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. I last attended the deceased from 7-5 1967, to 11-5, 1967, and that death occurred at 2:35 PM m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. E. SWINDELL M.D. 518	M.A.	VA CENTER, BOISE, IDAHO.	11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11-7-67	Puyallip Cemetery	Puyallip, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-7-67	Myrtle Palmer	Eldon T. Pearson Eldon T. Pearson	E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 13 1967

JAN 22 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Blackburn

Certificate of Death

State File No. 4719
Local Reg. No. 612
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Treasure Valley Manor

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FLORENCE	BENSON	JONASSON	Nov. 5 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	July 31 1879	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	House work	Logan, Utah	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George T. Benson	Garden Grove, Iowa	Louise Ballif	Lusanne, Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	529-10-8167	C. B. Jonasson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 492X Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes, senility.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct, 1967 *to* Nov 5, 1967 *that I last saw the deceased alive on* Nov 3, 1967, *and that death occurred at* 2:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
O. R. Blackburn M.D.		

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Nov. 8, 1967	Salt Lake City Cemetery	Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-9-67	Myrtle Palmer	Conway Grant	E-478

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 17 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4720
Local Reg. No. 617
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 17 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 3-01
b. CITY OR TOWN: Boise — LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hosp. 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: 070 Blaine
c. CITY OR TOWN: Hailey
d. STREET ADDRESS (If rural, give location): 417 2nd Ave. North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
KATHRYN	A.	GRAY	Nov. 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married 3	July 4, 1914	53				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
bookkeeper 08	Deputy Assessor	Goss, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
L.D. Yates	Missouri	Harriet Johnson	UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518-24-5911	Wm E. Gray	Hailey, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

330X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carotid aneurysm (left) — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rupture of carotid aneurysm (left)
DUE TO (c) Congenital defect.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11/6/67, 19 67, *to* 11/6/67, 1967, *that I last saw the deceased alive on* 10:35 a.m. 11/6/67, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Howard Dwight M.D.	616 Eastman Bldg. Boise	11/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City or town, county) (State)
removal 3	11/14/67	Hailey Cemetery	Hailey, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-15-67	Myrtle Palmer	[signature]	E-483

FIRM NAME: SUMMERS Funeral home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 22 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4121
Local Reg. No. 634
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada — NOV 27 1967 — 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics place): Boise
c. LENGTH OF STAY IN THIS PLACE: 3 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 292 Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 390 Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location): 334 Van Buren

3. NAME OF DECEASED (Type or Print): a. (First) EMILY — b. (Middle) ESTELLA (ESSIE) — c. (Last) SLUDER

4. DATE OF DEATH (Month) (Day) (Year): Nov. 6, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 17, 1891

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lafayette, Georgia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Vincent G. Ditmore — BIRTHPLACE: Georgia

14. MOTHER'S MAIDEN NAME: Minnie Williams — BIRTHPLACE: Lafayette, Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 519-26-[illegible]232

17. INFORMANT'S OWN SIGNATURE: By telephone — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4200 DSHD — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) arteriosclerosis — 2 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: old CVA — 11 mos.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 23 Feb, 1967, *to* 5 Nov, 1967, *that I last saw the deceased alive on* 27 Oct, 1967 *and that death occurred at* 9:30 PM *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 212 — (Degree or title): MD — **23b. ADDRESS**: 6003 Overland Rd. Boise Ida. — **23c. DATE SIGNED**: 27 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3 — **24b. DATE**: 11-7-67 — **24c. NAME OF CEMETERY OR CREMATORY**: — **24d. LOCATION** (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: 11-27-67 — **REGISTRAR'S SIGNATURE**: Myrtle Palmer

25. EMBALMER: [signature] — **LICENSE NO.**: E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 2 7 1967

JUN 18 1937

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to [illegible] the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4722
Local Reg. No. 237
Reg. Dist. No. 370

BIRTH NO. / certified copy

RECEIVED NOV 28 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: ADA 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (in this place): YEARS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1003 LINCOLN 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 001 ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1003 LINCOLN

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	FLOYD	B.	COCKRILL	NOV. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	MARRIED 3	OCT. 14, 1890	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
TRUCK DRIVER 27	CIVIL SERVICE	CAMARGO, ILL.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
THOMAS T. COCKRILL	KANSAS	MARY E. WELLS	ILL.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES	WWI 3	518-07-0994	x Anna M. Cockrill	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 4, 1967, *to* Nov 7, 1967, *that I last saw the deceased alive on* Nov 4, 1967, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ray Barry	M.D.	Boise, Idaho	11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	11/10/67	CLOVERDALE MEMORIAL PARK	BOISE, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-28-67	Myrtle Palmer	G. W. WATERS G. W. Waters	E-461

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: CLOVERDALE FUNERAL HOME

DUTIES:

NOV 28 1967

DEC 9 1992

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4723
Local Reg. No. 616
Reg. Dist. No. 370

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011 NOV 13 1967 1-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics) BOISE
c. LENGTH OF STAY (in this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) RESIDENCE, 2700 CHITWOOD WAY 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY ADA 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
d. STREET ADDRESS (If rural, give location) 2700 CHITWOOD WAY

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) A. c. (Last) COWAN

4. DATE OF DEATH (Month) (Day) (Year) NOV. 7, 1967

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3
8. DATE OF BIRTH 10 - 27 - 1923
9. AGE (In years last birthday) 44 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jeweler Watch repairman
10b. KIND OF BUSINESS OR INDUSTRY truck driver 21 laborer
11. BIRTHPLACE (State or foreign country) Hammett, Idaho
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Wm. Hector Cowan — BIRTHPLACE Glein Veigh, Ireland
14. MOTHER'S MAIDEN NAME Linnie Grace Green — BIRTHPLACE Vernal, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW11 4
16. SOCIAL SECURITY NO. 518-30-0447
17. INFORMANT'S OWN SIGNATURE Vanda Cowan — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma left lung — INTERVAL BETWEEN ONSET AND DEATH 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Esophageal extension of cancer — 1 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Robert H Holdren 236 (Degree or title) MD.
23b. ADDRESS 201 W Sate St Boise
23c. DATE SIGNED 13 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 1967 November 10
24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 11-13-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Conway Grant
LICENSE NO. E 478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 24 1997

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4724
Local Reg. No. 228
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011 000
b. CITY OR TOWN Boise, Idaho
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise, Idaho
d. STREET ADDRESS (If rural, give location) 3135 Sycamore Drive

3. NAME OF DECEASED (Type or Print)
a. (First) Elsie
b. (Middle) M.
c. (Last) Roberts

4. DATE OF DEATH (Month) (Day) (Year) Nov. 8, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Feb. 17, 1887
9. AGE (In years last birthday) 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretarial 19
10b. KIND OF BUSINESS OR INDUSTRY power Company
11. BIRTHPLACE (State or foreign country) Western, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jonathan Enoch Roberts
BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Mary Alpha Gipple
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-07-3040
17. INFORMANT'S OWN SIGNATURE Mrs E. E. Loughrey
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3347

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral V Sclerosis
INTERVAL BETWEEN ONSET AND DEATH progressive

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___ and that death occurred at _____ m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 3/8 MD
23b. ADDRESS 401 N. Orchard Boise Idaho
23c. DATE SIGNED 11-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Morris Hill
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 11-17-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER
LICENSE NO. E-460
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 0 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 7 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4725
Local Reg. No. 679
Reg. Dist. No. 370

BIRTH NO.

NOV 17 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada 13-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 wk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Rural
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Loyd
c. (Last): Mc Grath

4. DATE OF DEATH (Month) (Day) (Year): Nov. 8, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 6, 1906
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Mc Grath — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Minnie Arboaugh — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-07-1574
17. INFORMANT'S OWN SIGNATURE: Mildred McGrath — ADDRESS: Rt. 1 Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

154X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer of the rectum with metastases

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH: 8 1/2 to 4 yrs

19a. DATE OF OPERATION: 11-8-65
19b. MAJOR FINDINGS OF OPERATION: Cancer of the rectum
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 1, 1965, *to* Nov 8, 1967, *that I last saw the deceased alive on* Nov 8, 1967, *and that death occurred at* 4:10P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 167 M.D.
23b. ADDRESS: 123 E. Idaho St - BOISE
23c. DATE SIGNED: Nov 13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-11-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-17-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jerread
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

DUTIES:

NOV 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4726
Local Reg. No. 229
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 8201 Overland Rd.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Orville	H.	Shipman	Nov.	9	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Nov. 30, 1895	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): steamfitter 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oshawa, Ontario, Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Shipman	Ont., Canada	Mary Jane Wilson	Ont., Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWI 3	519-20-0500	Earl Alden	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1530 Carcinoma of the Cecum — INTERVAL BETWEEN ONSET AND DEATH: 4 wks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/7, 1967, *to* 11/9, 1967, *that I last saw the deceased alive on* 11/9, 1967, *and that death occurred at* 9:30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Walter H. Weis 654 (Degree or title) M.D.	425 W. Bannock Boise	11/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-13-67	Morris Hill	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-17-67	Myrtle Palmer	Earl H. Alden	E-460

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 21 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4727
Local Reg. No. 226
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Plymouth
d. STREET ADDRESS (If rural, give location): 100 So. Plymouth

3. NAME OF DECEASED (Type or Print)
a. (First): RICHARD
b. (Middle): WARD
c. (Last): JOHNS

4. DATE OF DEATH (Month) (Day) (Year): Nov. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: July 26, 1965
9. AGE (In years last birthday): 2 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02
10b. KIND OF BUSINESS OR INDUSTRY: never worked
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rex William Johns — BIRTHPLACE: New Mexico
14. MOTHER'S MAIDEN NAME: Carolyn Fae Ward — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Rex W. Johns — ADDRESS: New Plymouth, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1934

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Neuroblastoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 11/10/67
19b. MAJOR FINDINGS OF OPERATION: Neuroblastoma c̄ metastasis
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11-9, 1967, *to* 11-10, 1967, *that I last saw the deceased alive on* 11-10, 1967, *and that death occurred at* 8:25 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl M Johnston MD 264
23b. ADDRESS: 8482 Cassia Dr Boise
23c. DATE SIGNED: 11/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/13/1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett Cemetery
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: 11-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Marvin R. Heikkila — LICENSE NO.: E - 515
FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 3 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Johnston

67-9369 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4728
Local Reg. No. 614
Reg. Dist. No. 370

BIRTH NO.

NOV 14 1967

Bureau of Vital Statistics 2-01

1. PLACE OF DEATH

a. COUNTY: Ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (in this place): 5 Weeks

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: 011 Ada

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: Boise

d. STREET ADDRESS (If rural, give location): 8220 Crestwood Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Mark	Andrew	Netson	Nov. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	Oct. 1, 1967	5 Weeks		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Child 02	Child	Boise, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Netson	Kansas	Sharon Morand	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	No.	Robert S. Netson	Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2893 Pneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Meconium Ileus

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: (a) 1 Wk. (b) (c) (II)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10/9/67	Small Bowel Obstruction see (b) above.	YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-1, 1967, *to* 11-10, 1967, *that I last saw the deceased alive on* 11-10, 1967, *and that death occurred at* 4:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Carl M. Johnston 2604	M.D.	844 Boise Manor Blvd	11/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11-10-67	Topeka Cemetery	Topeka, Kansas

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-10-67	Myrtle Palmer	Daniel G. Gibson	400

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Gibson Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4729
Local Reg. No. 181
Reg. Dist. No. 371

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 17 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1-02 1 yr. 11 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION Sunset Nursing Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1411 N. 16th Street

3. NAME OF DECEASED (Type or Print) a. (First) CHLOE b. (Middle) M. c. (Last) BROWN

4. DATE OF DEATH (Month) Nov. (Day) 10 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH May 23, 1871

9. AGE (In years last birthday) 96 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Deweyville, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME E. M. Slocum BIRTHPLACE Pennsylvania

14. MOTHER'S MAIDEN NAME Margaret A. Wells BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-60-4015

17. INFORMANT'S OWN SIGNATURE # E. V. Vail ADDRESS Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 10 da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Malnutrition — 2 yrs

DUE TO (c) Senility — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Recorded ulcers — 6 mo

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-20, 1965 *to* 11-10, 1967, *that I last saw the deceased alive on* 11-9, 1967, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Carl B. Knutson 484 (Degree or title) MD

23b. ADDRESS Boise Idaho

23c. DATE SIGNED 11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 14/67

24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery

24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 11-15-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Powell M. Summers

LICENSE NO. E 509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4730
Local Reg. No. 183
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE, IDAHO
c. LENGTH OF STAY (in this place): 27 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA CENTER, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: CALIFORNIA 05
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BEAUMONT
d. STREET ADDRESS (If rural, give location): 1122 E. 8th

3. NAME OF DECEASED (Type or Print)
a. (First): CARL
b. (Middle): K.F.
c. (Last): CARDEN

4. DATE OF DEATH (Month) (Day) (Year): 11-10-67

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced 4

8. DATE OF BIRTH: 3-8-20

9. AGE (In years last birthday): 47 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): bartender 23

10b. KIND OF BUSINESS OR INDUSTRY: same

11. BIRTHPLACE (State or foreign country): Wellington Illinois

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: John B. Carden — BIRTHPLACE: Tenn.

14. MOTHER'S MAIDEN NAME: Stella Harris — BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWII 4

16. SOCIAL SECURITY NO.: 351-10-74-58

17. INFORMANT'S OWN SIGNATURE: Dora Allen — ADDRESS: VA HOSPITAL RECORDS, BOISE, IDAHO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1992

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~xxxxxx~~ Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 1 Day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Trauma, surgical — 3 Days

DUE TO (c) Multiple carcinomas: (1) Floor of mouth; (2) Esophagus; (3) Left stem bronchus — Approx. 1 Yr.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: 11-7-67

19b. MAJOR FINDINGS OF OPERATION: Suboccipital craniotomy with tractotomy brain stem and 9th nerve section.

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ I attended the deceased from 3-28-67, 19__, to 11-10, 1967, ~~that I last saw the deceased alive on~~, and that death occurred at 11:35 A m., from the causes and on the date stated above.

23a. SIGNATURE Wm. W. Laxson (Degree or title): 597 W. W. LAXSON, M.D. (FOR: R. J. Bungard, M.D.)

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-14-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-17-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature]

LICENSE NO.: E-460

FIRM NAME: McBratney-Alden-Waggoner

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

NOV 2 0 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 12 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4731
Local Reg. No. 646
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian 000
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 116 E. Broadway

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian rural
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print): a. (First) Daniel b. (Middle) L. c. (Last) Barker

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov. 1, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): North Platt, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Daniel L. Barker — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Addie Clark — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-12-7087
17. INFORMANT'S OWN SIGNATURE: Dan Barker — ADDRESS: Rt. 2 Meridian

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): cardiac arhythmia — INTERVAL BETWEEN ONSET AND DEATH: 3 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASHD — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: None

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* never *to* _____, 19____, *that I last saw the deceased alive on* 10 Nov, 1967, *and that death occurred at* 3:45p *m., from the causes and on the date stated above.*

23a. SIGNATURE: Lee L Williams (Degree or title) MD
23b. ADDRESS: 925 E 1st Meridian
23c. DATE SIGNED: 13/Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-14-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: 11-29-67
REGISTRAR'S SIGNATURE: Myrtle Palmer Myrtle Palmer
25. EMBALMER: Desmond
LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4732
Local Reg. No. 627
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 22 1967 3-07 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1115 North 5th.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Nellie	Ireton	Mills	Nov. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	April 23, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife C/	Home	Montour, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John H. Ireton	Ohio	Josephine Warner	Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	519-16-1649	James R Mills	Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial Failure	3 months
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease	10 years
DUE TO (c)	Arteriosclerosis	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Uremia, Pneumonitis	7 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8/6, 1958, *to* 11/10, 1967, *that I last saw the deceased alive on* 11/10, 1967, *and that death occurred at* 11:10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. Gardner, MD 421	Boise	11/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-14-67	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-20-67	Myrtle Palmer	Daniel G. Gibson	E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4733
Local Reg. No. 184
Reg. Dist. No. 271

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 001 — 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE, IDAHO — LENGTH OF STAY (in this place): 53 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA CENTER, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO — b. COUNTY: 161 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BURLEY
d. STREET ADDRESS (If rural, give location): 1850 Jackson Ave

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	JAMES	W.	ROBERTS	11	11	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	6-22-15	52		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Desk Sgt. 08	Police Dept.	Cokeville, Wyoming	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William C. Roberts	Wyoming	Rosetta Welker	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWII 4	518-09-5928	Edna Allen	VA Hospital Records, Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Broncho-esophageal fistula — 2 Weeks
DUE TO (c) Bronchogenic carcinoma — 6-9 Months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-25-67	Bronchogenic carcinoma with broncho-esophageal fistula.	YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
VA m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. ~~I was present at the autopsy.~~ I attended the deceased from 9-19, 1967, to 11-11, 19 67, ~~I last saw the deceased alive on~~, and that death occurred at 11:15 p.m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm. W. Laxson 594 W. W. LAXSON, M.D. (FOR: R. J. BUNGARD, MD)	VA CENTER, BOISE, IDAHO	11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL 3	Nov. 12, 1967		Burley Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-20-67	Myrtle Palmer	Howell A. Summers	E-509

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 22 1967

FEB 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal. . .

ADDITIONAL REMARKS by Physician.....

State File No. 4734
Local Reg. No. 182
Reg. Dist. No. 371

RECEIVED NOV 20 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 000
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hyway 16 2miles No of 44 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 917 So. Washington

3. NAME OF DECEASED (Type or Print)
a. (First): Rada
b. (Middle): Marie
c. (Last): Hill

4. DATE OF DEATH (Month) (Day) (Year): Nov.11,1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Apr.13,1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Salem, Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Isaac N. Zink — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Dora Harmon — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-07-1231
17. INFORMANT'S OWN SIGNATURE: X Van N. Zink — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Head & Brain Injury — INTERVAL BETWEEN ONSET AND DEATH: Inst;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 000 13
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): II II 67 730A
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto Accident Lost Control, Roll Over.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 730A *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title): Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: II-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial 1
24b. DATE: Nov.14,1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: 11-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E392
FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 23 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4735
Local Reg. No. 618
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
NOV 16 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 55 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 921 North Tenth Street

3. NAME OF DECEASED (Type or Print)
a. (First): BENJAMIN
b. (Middle): CARL
c. (Last): BAILEY

4. DATE OF DEATH (Month) (Day) (Year): November 11, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Feb. 15, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired minister 18
10b. KIND OF BUSINESS OR INDUSTRY: Presbyterian Church
11. BIRTHPLACE (State or foreign country): Piqua, Ohio
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry P. Bailey — BIRTHPLACE: ---
14. MOTHER'S MAIDEN NAME: Cynthia Green — BIRTHPLACE: ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 519-36-0701
17. INFORMANT'S OWN SIGNATURE: 921 N. 10th ADDRESS Boise
X Mrs. Benjamin C. Bailey

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1962 Malignant Lesion T12 of spine — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) not determined
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/15, 1967, *to* 11/11, 1967, *that I last saw the deceased alive on* 11/11, 1967, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 421 M.
23b. ADDRESS: Boise
23c. DATE SIGNED: 11/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 11-16-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-509

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4736
Local Reg. No. 622
Reg. Dist. No. 370

RECEIVED NOV 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route 2, Ruth Street

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): Bennet
c. (Last): Hedstrom

4. DATE OF DEATH (Month) (Day) (Year): Nov. 11, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 11, 1903
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sandstone, Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: C.A. Hedstrom — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Elizabeth Sealin — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 700-01-4581
17. INFORMANT'S OWN SIGNATURE: Mrs Charles Hedstrom — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 464X Massive Pulmonary Infarction — INTERVAL BETWEEN ONSET AND DEATH: approx 10 min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Peripheral Thrombophlebitis — 2 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Cholecystectomy and Repair Hiatal Hernia — 2 days

19a. DATE OF OPERATION: 11/9/67
19b. MAJOR FINDINGS OF OPERATION: Cholelithiasis, Hiatal Hernia
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/6, 1967, *to* 11/11, 1967, *that I last saw the deceased alive on* 11/11, 1967, *and that death occurred at* 6:55 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ralph R. Jones, M.D. 270
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 11/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 11-17-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Leach M. Sears
LICENSE NO.: E-460

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McBratney-Alden-Waggoner

NOV 2 0 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4737
Local Reg. No. 615
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 14 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4101 PALOUSE ST. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY ADA 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) ~~BOISE~~ MERIDIAN
d. STREET ADDRESS (If rural, give location) ROUTE # 2

3. NAME OF DECEASED (Type or Print) a. (First) RICHARD b. (Middle) VERNON c. (Last) BALL

4. DATE OF DEATH (Month) NOV. (Day) 11, (Year) 1967

5. SEX MALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3
8. DATE OF BIRTH SEPT. 26, 1911
9. AGE (In years last birthday) 56 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LUMBER BUSINESS 17
10b. KIND OF BUSINESS OR INDUSTRY LUMBER
11. BIRTHPLACE (State or foreign country) BUFFALO, MISSOURI
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME COREBETT BALL BIRTHPLACE UNKNOWN
14. MOTHER'S MAIDEN NAME MYRTLE PRICE BIRTHPLACE UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 440-16-4738
17. INFORMANT'S OWN SIGNATURE X Mrs. James Stogsdill ADDRESS Rt 2 Meridian Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by Carbon-Monoxide Smoke Fumes.
INTERVAL BETWEEN ONSET AND DEATH Mins:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Back side body partly burned.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Had been smokeing in chair. evidently dropped cigarette in chair. smoldered. then blazed up while asleep.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 00
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 000 13 (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19, to, 19, *that I last saw the deceased alive on* , 19, *and that death occurred at* 3 A m., *from the causes and on the date stated above.*

23a. SIGNATURE E. L. Davis 583 (Degree or title) Coroner
23b. ADDRESS 3720 Meadow Drive. Boise.
23c. DATE SIGNED II-II-67.

24a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL 3
24b. DATE NOV. 12, 1967
24c. NAME OF CEMETERY OR CREMATORY SENECA CEMETERY
24d. LOCATION (City, town, or county) SENECA (State) MISSOURI

DATE REC'D BY LOCAL REG. 11-13-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER G. W. WATERS
LICENSE NO. E-461

FIRM NAME: CLOVERDALE FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4738
Local Reg. No. 623
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 3-06 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Camas 130
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hill City
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Doris
b. (Middle) Marian
c. (Last) Stokes

4. DATE OF DEATH (Month) Nov. (Day) 12 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan. 31, 1920
9. AGE (In years last birthday) 47 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Hagerman, Idaho.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Silas Condit — BIRTHPLACE Malta, Idaho.
14. MOTHER'S MAIDEN NAME Reveria Gilmore — BIRTHPLACE Fairland, Oklahoma.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE x Marvin Stokes — ADDRESS Boise, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

9160

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 3° burn 85% body — INTERVAL BETWEEN ONSET AND DEATH 5 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 00
21c. (CITY, TOWN, OR TOWNSHIP) 13 Hillcity Idaho (COUNTY) ~~000~~ 130 (STATE)

21d. TIME OF INJURY (Month) 11 (Day) 5 (Year) 67 (Hour) 9P m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-6, 1967, *to* 11-12, 1967, *that I last saw the deceased alive on* 11-12, 1967, *and that death occurred at* 3p *m., from the causes and on the date stated above.*

23a. SIGNATURE E. D. Jones Jr. 268 (Degree or title) M.D. 1
23b. ADDRESS 318 First Nat Bank Boise Idaho
23c. DATE SIGNED 11-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 11-15-1967
24c. NAME OF CEMETERY OR CREMATORY Hagerman Cemetery
24d. LOCATION (City, town, or county) Hagerman (State) Gooding, Idaho.

DATE REC'D BY LOCAL REG. 11-20-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Robert J. Meyer — LICENSE NO. E-424
FIRM NAME Thompson Chapel Gooding, Idaho.

Federal Security Agency
United States Public Health Service
Form DH-63021

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 1 - 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4739
Local Reg. No. 186
Reg. Dist. No. 271

BIRTH NO.

RECEIVED
NOV 2 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2-02 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 11651 Fairview Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SUSIE	M.	GRAUBERGER	Nov. 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	July 11, 1920	47				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Sennica, South Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ole Larson	Unknown	Cordelia Elliott	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-14-2001	Lee L Grauberger	

MEDICAL CERTIFICATION

5271

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema — INTERVAL BETWEEN ONSET AND DEATH: Mins;

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) Ill for years. Oxygen used for 3 months — 3 Mos;

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* did Not See Alive, 19, *to* 19, *that I last saw the deceased alive on* , 19 *and that death occurred at* I A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 G. W. Waters Coroner	3720 Meadow Drive, Boise.	11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/17/67	Cloverdale Memorial Park	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-20-67	Myrtle Palmer	G. W. Waters G W Waters	E-461

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 31 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 6 1968

FEB 26 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4740
Local Reg. No. 628
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 22 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 2-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2204 Madison

3. NAME OF DECEASED (Type or Print)
a. (First): Gladys
b. (Middle): Imogene
c. (Last): Sill

4. DATE OF DEATH (Month) (Day) (Year): Nov. 14, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 19, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Emmett, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clayton Maulton — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Saraha Marchel — BIRTHPLACE: Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-09-9682D
17. INFORMANT'S OWN SIGNATURE: Roy M. Harkelmode — ADDRESS: Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH: 5-6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1951, *to* Nov., 1967, *that I last saw the deceased alive on* 8 Nov., 1967, *and that death occurred at* 6:00 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Max L. Bell, M.D. 039
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 11-17-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 11-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Daniel G. Gibson — LICENSE NO.: E-400

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4741
Local Reg. No. 185
Reg. Dist. No. 371

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 22 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA. 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE, IDAHO. 3-07
LENGTH OF STAY (in this place) 8 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA CENTER, BOISE, IDAHO. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 370 Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) HOMEDALE.
d. STREET ADDRESS (If rural, give location) HOMEDALE NURSING HOME.

3. NAME OF DECEASED (Type or Print)
a. (First) ENOS
b. (Middle) NMI.
c. (Last) CAMPBELL

4. DATE OF DEATH (Month) 11 (Day) 14 (Year) 67

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) NEVER MARRIED 1

8. DATE OF BIRTH 8-02-90

9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months 3 Days 12 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laundry Driver. 27

10b. KIND OF BUSINESS OR INDUSTRY Same

11. BIRTHPLACE (State or foreign country) Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME DAN CAMPBELL — BIRTHPLACE UNKNOWN

14. MOTHER'S MAIDEN NAME UNKNOWN — BIRTHPLACE UNKNOWN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES — (If yes, give war or dates of service) WW 1 3

16. SOCIAL SECURITY NO. 519 09 0392

17. INFORMANT'S OWN SIGNATURE [signature] — ADDRESS VA HOSPITAL RECORDS, BOISE, IDAHO.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia and pulmonary infarction — INTERVAL BETWEEN ONSET AND DEATH 8-10 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Necrotic cystitis — 10 days +
Chronic pyelonephritis — Unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES XXX NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. XX attended the deceased from 11-6, 1967, to 11-14, 1967 XX and that death occurred at 8:15PM m., from the causes and on the date stated above.

23a. SIGNATURE Robert C. Lewis, M.D. (Degree or title) ROBERT C LEWIS, M.D. 597

23b. ADDRESS VA CENTER, BOISE, IDAHO.

23c. DATE SIGNED 11-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 11/17/67

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill

24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. 11-20-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER [signature] — LICENSE NO. E393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 30 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4742
Local Reg. No. 631
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 24 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 3da.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Building under construction-Myrtle-S.Capitol Blvd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 45 UTAH
b. COUNTY: SALT LAKE 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): SALT LAKE CITY
d. STREET ADDRESS (If rural, give location): 1138 GIRARD AVE.

3. NAME OF DECEASED (Type or Print)
a. (First): JOSEPH
b. (Middle): LAWRENCE
c. (Last): SWIFT

4. DATE OF DEATH (Month) (Day) (Year): 11-14-67

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: 12-13-25
9. AGE (In years last birthday): 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction 11
10b. KIND OF BUSINESS OR INDUSTRY: Upholster
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph H. Swift — BIRTHPLACE: unk.
14. MOTHER'S MAIDEN NAME: Daisy Lawrence — BIRTHPLACE: unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW # 2
16. SOCIAL SECURITY NO.: 4529-18-9360
17. INFORMANT'S OWN SIGNATURE: Velma C. Swift — ADDRESS: 1138 Girard Ave. Salt Lake City Utah

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
No Former record. expired while working.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 620P *m., from the causes and on the date stated above.*

23a. SIGNATURE 583 — [signature] (Degree or title) Coroner 4
23b. ADDRESS: 3720 Meadow Drive.Boise
23c. DATE SIGNED: II-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3
24b. DATE: 11/15/67
24c. NAME OF CEMETERY OR CREMATORY: Wasatch Lawn
24d. LOCATION (City, town, or county) (State): SALT LAKE CITY, UTAH

DATE REC'D BY LOCAL REG.: 11-24-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Richard L. Nears — LICENSE NO. E443
MOUNTAIN VIEW FUNERAL HOME, BOISE

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 24 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 24 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4743
Local Reg. No. 233
Reg. Dist. No. 370

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN Boise
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 701 Franklin

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Ella	May	Stenson		Nov.	14	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Sept. 26, 1866	101				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Levi Pritchard — BIRTHPLACE New York
14. MOTHER'S MAIDEN NAME Margaret Campbell — BIRTHPLACE Ontario, Can.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-60-0011
17. INFORMANT'S OWN SIGNATURE E. E. Olsen — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 3 1
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—	—	—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* 12/2, 1958, *to* 11/14, 1967, *that I last saw the deceased alive on* 3/8, 1967, *and that death occurred at* 3:25 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Boise	11/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-17-67	Cloverdale	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-24-67	Myrtle Palmer	[signature]	E-460

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4744
Local Reg. No. 638
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 813 North 13th.

3. NAME OF DECEASED (Type or Print)
a. (First): Gustave
b. (Middle): (Gus)
c. (Last): Proesch

4. DATE OF DEATH (Month) (Day) (Year): November 15, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 28, 1885
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofer 21
10b. KIND OF BUSINESS OR INDUSTRY: Boise Gas Co.
11. BIRTHPLACE (State or foreign country): Farihaven, Minn.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wilkiam Proesch — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Caroline Rohurich — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.: 518-38-0870
17. INFORMANT'S OWN SIGNATURE: Bessie Proesch — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

022X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Rupture of aneurysm of aorta — INTERVAL BETWEEN ONSET AND DEATH: 30 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9-28-67
19b. MAJOR FINDINGS OF OPERATION: Enlarged prostate
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 2, 1958, *to* Nov 15, 1967, *that I last saw the deceased alive on* Nov 14, 1967, *and that death occurred at* 5 m., *from the causes and on the date stated above.*

23a. SIGNATURE: F B Jepperson 259 (Degree or title): M.D.
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 11/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-18-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county): Boise Ada (State): Idaho

DATE REC'D BY LOCAL REG.: 11-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Daniel G. Gibson — LICENSE NO.: E-400

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4745
Local Reg. No. 629
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 001 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 719 N. 7th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Nora
b. (Middle): Hoff
c. (Last): Kessler

4. DATE OF DEATH (Month) (Day) (Year): Nov. 15, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Mar. 19, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Credit Mgr. 26
10b. KIND OF BUSINESS OR INDUSTRY: Retail Stores
11. BIRTHPLACE (State or foreign country): Crookston, Minn.
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Hans T. Hoff — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Anna Durdahl — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-12-4391
17. INFORMANT'S OWN SIGNATURE: x Theodore Hoff — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Metastatic carcinoma of breasts. — INTERVAL BETWEEN ONSET AND DEATH: 6 yrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1965, *to* 11-15, 1967, *that I last saw the deceased alive on* 11-14, 1967, *and that death occurred at* 3 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): D. B. Patterson 412 MD
23b. ADDRESS: Boise
23c. DATE SIGNED: 11-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-460

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alden-Waggoner

DEC 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4746
Local Reg. No. 187
Reg. Dist. No. 371

Certificate of Death

RECEIVED NOV 28 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada. 011 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (In this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho.
b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 1523 Hays Street

3. NAME OF DECEASED (Type or Print)
a. (First): Arthur
b. (Middle): F
c. (Last): RIDDLE

4. DATE OF DEATH (Month) 11 (Day) 15 (Year) 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: 6-18-86
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Veterans Claims Exam. 08
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alexander Riddle. BIRTHPLACE: PA.
14. MOTHER'S MAIDEN NAME: Ada Fuller. BIRTHPLACE: Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 518 09 8581
17. INFORMANT'S OWN SIGNATURE: John D. Stock — ADDRESS: VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arterio Sclerotic Heart Disease. — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that I~~ attended the deceased from 11-15, 1967, to 11-15-67, 19 ~~, that I last saw the deceased alive on~~ ~~, 19~~ and that death occurred at 8:45PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): F. W. Nolan, M.D. 597
23b. ADDRESS: VA Center, Boise, Idaho
23c. DATE SIGNED: 11-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-18-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-24-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. Dale McMurtrey
LICENSE NO.: E-410
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 20 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 13 1983

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 6 1967 Bureau of Vital Statistics

State File No. 4747
Local Reg. No. 666
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 67 27 Fairview Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Eva	B	Errico	11-15-67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Divorced 4	10-30-86	81		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher 12	Public Schools	Wallingford, Conn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unk.		Unk.	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		527-42-5923-A	E.D. Evans	Ada Co. Coroner

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atherosclerotic Cardiovascular disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11/9, 1967, *to* 11-15, 1967, *that I last saw the deceased alive on* 11-15-, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Thomas D. Merrill M.D.	357	Boise Ida	11/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
CREMATION	11/27/67	MOUNTAIN VIEW CREMATORY	BOISE, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-4-67	Myrtle Palmer	Richard L. Mans	E-443

FIRM NAME: MOUNTAIN VIEW FUNERAL HOME, BOISE, IDA.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4748
Local Reg. No. 659
Reg. Dist. No. 370

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 730 Shayne Drive

3. NAME OF DECEASED (Type or Print)
a. (First): HAZEL
b. (Middle): E.
c. (Last): SWEET

4. DATE OF DEATH (Month) (Day) (Year): November 16, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: June 27, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Springfield, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Hillman — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Laura Bishop — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-36-9083
17. INFORMANT'S OWN SIGNATURE: Mrs Sylvan Jeppesen — ADDRESS: Boise, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

296X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Thrombocytopenia.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Skin, renal, stomach hemorrhages

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/5, 1967, *to* 11/16, 1967, *that I last saw the deceased alive on* 11/16, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Allohany, M.D. 095
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 11/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls Idaho

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Howell Demaray
LICENSE NO.: E-509

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

1418 Wilson

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4749
Local Reg. No. 232
Reg. Dist. No. 370

RECEIVED NOV 24 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 3-10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — LENGTH OF STAY (In this place): 10days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2319 Irene Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Leslie	V	Rothrock	11-17-67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	11-7-94	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Liquid Gas 06	same	Red Cloud, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John S. Rothrock	Indiana	Emma Wittwer	unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Mrs. Frances Rothrock	2319 Irene

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Advanced Cerebro Vascular ateriosclerosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ateriosclerosis - with multiple thrombosis - Anemia, — 13 Months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cervicy tract infection.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1962, 19__, *to* 11-17-67, 19__, *that I last saw the deceased alive on* 11-17-67, 19__, *and that death occurred at* 7:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. D. Springer MD 491	220 N 8th Boise Ida	11-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
ENTOMBMENT	11-21-67	MOUNTAIN VIEW MAUSOLEUM	* Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	EMBALMER	LICENSE NO.
11-24-67	Myrtle Palmer	Leonard L. Mann	E-443

Federal Security Agency
United States Public Health Service

Form DH-63021

MOUNTAIN VIEW FUNERAL HOME, BOISE, IDA.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. - In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4750
Local Reg. No. 232
Reg. Dist. No. 370

RECEIVED
NOV 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 33 New York
b. COUNTY: 535 Oswego
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Oswego
d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Dianne	M.	Herrmann	11-17-67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	12-18-46	20		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	College	Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Leonard F. Swartz	N. Dakota	Della Johnson	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	unk.	E. Parris	Ada Co. Coroner

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Self Inflicted gun shot in Head — INTERVAL BETWEEN ONSET AND DEATH: 30 Mins

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Husband and wife seperation & Despondente

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Suicide 2	In Auto 26	13 So-of Boise	Ada 011	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY Ooccur?
11 17 67 640P	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	

22. *I hereby certify that I attended the deceased from* Did Not to See Alive, 19___, *that I last saw the deceased alive on* ___, 19___ *and that death occurred at* 640P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. Parris 583	Coroner	3720 Meadow Drive, Boise.	11-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11-18-67	Sunset Mem. Gardens	Missoula, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	EMBALMER	LICENSE NO.
11-27-67	Myrtle Palmer	Leonard L. Mass	E-[illegible]3

NAME AND ADDRESS OF FUNERAL HOME: MOUNTAIN VIEW FUNERAL HOME, Boise, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Sam Taylor

Certificate of Death

STATE OF IDAHO

State File No. 4751
Local Reg. No. 188
Reg. Dist. No. 371

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

BIRTH NO.

1-15

1. PLACE OF DEATH
a. COUNTY: Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
LENGTH OF STAY (in this place): 15 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence Route 3, 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Ada 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Meridian
d. STREET ADDRESS (If rural, give location): Route 3, Meridian, Idaho

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RAY	CHARLES	RICH	Nov. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	May 13, 1890	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	St. Charles, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hyrum S. Rich	Mt. Pisgah, Iowa	Elizabeth Stock	Port Elizabeth, Africa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-07-6905 A	Vernon B. Rich	Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Abdominal Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10/30/67	Advanced	YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9/8, 1967 *to* 11/18, 1967, *that I last saw the deceased alive on* 11/15, 1967 *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
S. C. Taylor	524 MD	619 Canyon Nampa	11/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-21-67	St. Charles, Cemetery	St. Charles, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-27-67	Myrtle Palmer	Conway Grant	E478

FIRM NAME: GELYEA MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 16 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 2 1982

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 16 1984

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4752
Local Reg. No. 660
Reg. Dist. No. 270

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 016 Ada — DEC 5 1967 — 3-06
b. CITY OR TOWN Boise — Bureau of Vital Statistics — 15c. LENGTH OF STAY (If this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Meridian
d. STREET ADDRESS (If rural, give location) 1125 E. Pine

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	A.	Snyder	Nov. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Aug. 25, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04		Meridian, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Luther Snyder	Kansas	Susan E. Thomas	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		William Snyder	Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2001 Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH 18 mos.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-11, 1967, *to* 11-18, 1967, *that I last saw the deceased alive on* 11-17, 1967, *and that death occurred at* 4:38A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George R Baliey 019	M.D.	121 E. Idaho Boise	11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-21-67	Dry Creek Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-4-67	Myrtle Palmer	Leo Snead	E-366

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robison Chapel of the Chimes

NOV 16 1972

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4753
Local Reg. No. 189
Reg. Dist. No. 371

BIRTH NO.

RECEIVED NOV 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 01 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE, IDAHO.
LENGTH OF STAY (in this place): One Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 1119 Nth 23rd St

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Galen	F	PARIS	11	19	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	8-26-97	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Nebraska.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Arthur B Paris. BIRTHPLACE: Indiana.
14. MOTHER'S MAIDEN NAME: Mary A Waltz. BIRTHPLACE: Indiana.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 519035168
17. INFORMANT'S OWN SIGNATURE: John O Stark ADDRESS: VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial insufficiency — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atrial fibrillation — Unknown
DUE TO (c) Arteriosclerotic heart disease — Many yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I attended the deceased from 11-18, 19 67, to 11-19, 19 67, that I last saw the deceased alive on [illegible], and that death occurred at 8:15 AM m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. K. HELFERTY, M.D.	MD	VA Center, Boise, Idaho.	11-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	11-22-67	Morris Hill	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-27-67	Myrtle Palmer	Conway Grant	E478

FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

NOV 2 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 9 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

R C S 21-1

Certificate of Death

STATE OF IDAHO

State File No. 4754
Local Reg. No. 192
Reg. Dist. No. 271

BIRTH NO.

RECEIVED NOV 28 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA. 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Boise, Idaho Bureau 2-01
c. LENGTH OF STAY (in this place): 26 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 011

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho. b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 6523 North View

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Charles	A	FUCHS.	11	19	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	Married 3	5-11-99	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operating Engineer 21
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): New York.
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Marlin Fuchs. BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Magaline Unknown. BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW 1
16. SOCIAL SECURITY NO.: 554 30 0176
17. INFORMANT'S OWN SIGNATURE: John D. Fuchs ADDRESS: VA Hospital Records, Boise, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic carcinoma of brain — INTERVAL BETWEEN ONSET AND DEATH: 4 months +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchogenic carcinoma — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) VA m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-24, 1967 to 11-29, 1967, and that death occurred at 11:50PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis M.D. 597 M.D. ROBERT C LEWIS, M.D.	VA Center, Boise, Idaho	11-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	11/24/67	Cloverdale Memorial Park	Boise	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-28-67	Myrtle Palmer	G. W. Waters G. W. Waters	E-461

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 28 1967

NOV 29 1967

MAR 1 1968

MAR 25 1993

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4755
Local Reg. No. 649
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 13 days 3-13
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1620 Howry

3. NAME OF DECEASED (Type or Print)
a. (First): LILLIE
b. (Middle):
c. (Last): ERWIN

4. DATE OF DEATH (Month) (Day) (Year): November 19, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: July 12, 1872
9. AGE (In years last birthday): 95 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Anthony Nicholes — BIRTHPLACE: Austria
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 519-60-0288
17. INFORMANT'S OWN SIGNATURE: Jessie Daniels — ADDRESS: 1626 N. Howry Boise, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): advanced generalized arterio sclerosis with diabetes mellitus and cerebral arterio sclerosis

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH: years —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 Jan, 1963, *to* 19 Nov, 1967, *that I last saw the deceased alive on* 6 Nov, 1967, *and that death occurred at* 4:50p *m., from the causes and on the date stated above.*

23a. SIGNATURE: J Hugh Atchley 014 (Degree or title) MD
23b. ADDRESS: 401 Idaho St Boise Ida
23c. DATE SIGNED: 22 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: 11-30-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature] — LICENSE NO.: E-483

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Kiefer
EASTMAN B.

Certificate of Death

STATE OF IDAHO

3428221

State File No. 4756
Local Reg. No. 638
Reg. Dist. No. 370

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 3-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 7 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1302 North 7th.

3. NAME OF DECEASED (Type or Print)
a. (First): Magdalene
b. (Middle): Theresa
c. (Last): Andrews

4. DATE OF DEATH (Month) (Day) (Year): Nov. 20, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: July 19, 1913
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): V. A. Nurse 13
10b. KIND OF BUSINESS OR INDUSTRY: Nursing
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Paul Stadler — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Cora Mochel — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. 11 4
16. SOCIAL SECURITY NO.: 518-07-1263
17. INFORMANT'S OWN SIGNATURE: Aden Andrews — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

272X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Increased intracranial pressure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) cerebral edema.
DUE TO (c) Pituitary tumor

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. acute pulmonary edema

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: 11/16/67
19b. MAJOR FINDINGS OF OPERATION: Chromophobe adenoma Pituitary gland.
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-10-, 1967, *to* 11-20-, 1967, *that I last saw the deceased alive on* 11-20-, 1967, *and that death occurred at* 12:45 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edward Kiefer 281 M.D.
23b. ADDRESS: 616 Eastman Bldg. Boise, Ida.
23c. DATE SIGNED: 11-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 11-22-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 11-28-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS, by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4757
Local Reg. No. 685
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 27 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1009 O'Farrell

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
EMMA	J.	SUNDELL	November 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	August 25, 1876	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	at home	Smolend, Sweden	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Johnson	Sweden	No record	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	----	519-32-9135	Mabel C. Warberg	624 East Ash Caldwell, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma 1992

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Source Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-10, 1967, *to* 11-20, 1967, *that I last saw the deceased alive on* 11-13, 1967, *and that death occurred at* 7:40p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C.C. Johnson 261	MD	Boise Ida	11-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov. 22, 1967	Morris Hill Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-27-67	Myrtle Palmer	H.E. Walker	E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 2 7 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4758
Local Reg. No. 191
Reg. Dist. No. 371

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

NOV 29 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (in this place): One Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho.
b. COUNTY: 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise.
d. STREET ADDRESS (If rural, give location): 1st & Main Street

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): C
c. (Last): HENSON

4. DATE OF DEATH (Month) 11 (Day) 20 (Year) 67

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: 11-5-10
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laundryman. 06
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): Ill.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James H Henson. BIRTHPLACE: Ill
14. MOTHER'S MAIDEN NAME: Flossie Ballard. BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 334 10 80 31
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: VA Hospital Records, Boise, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9160

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Medical Burns 1st 2nd & 3rd degree 65% body — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): /
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP): Boise 13 — (COUNTY): Ada 011 — (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): VA m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Gas in patient's home exploded

22. ~~I hereby certify that I~~ attended the deceased from 11-20, 19 67, to 11-20, 19 67, ~~[illegible]~~ and that death occurred at 3:45PM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): J. K. HELFERTY, M.D. [signature] 597 MD
23b. ADDRESS: VA Center, Boise, Idaho.
23c. DATE SIGNED: 11-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 11-24-67
24c. NAME OF CEMETERY OR CREMATORY: Willamette Nat'l. Cem.
24d. LOCATION (City, town, or county) (State): Portland, Oregon

DATE REC'D BY LOCAL REG.: 11-27-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature] Richard L. Maus
LICENSE NO.: E-443

Federal Security Agency
United States Public Health Service
Form DH-63021

MOUNTAIN VIEW FUNERAL HOME, BOISE, IDA.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOTICES: FEB 26 196

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4759
Local Reg. No. 282
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 1 1967

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 | 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise,
d. STREET ADDRESS (If rural, give location): 309 E. Pennsylvania

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	FRED	MATTHEW	MURDOCK		11	20	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	July 2, 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Mechanic 21	Equip. Sales	Granger, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harry F. Murdock	Peoria, Ill.	Alice Warren	Green Rim, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Mrs Fred Murdock	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary heart disease — (7 ?) yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. 17, 1967, *to* Nov. 20, 1967, *that I last saw the deceased alive on* Nov. 29, 1967, *and that death occurred at* 3 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul F. Miner 364 MD	105 N. 8th St. Boise, Idaho	11/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/22/67	Dry Creek Cemetary	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-30-67	Myrtle Palmer	Conway Grant Conway Grant	E-476

FIRM NAME: REINEA MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 - 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 28 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signature of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 14 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4760
Local Reg. No. 661
Reg. Dist. No. 370

Certificate of Death

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 441 Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Martha
b. (Middle):
c. (Last): Wells

4. DATE OF DEATH (Month) (Day) (Year): 11 20 1967

5. SEX: female
6. COLOR OR RACE: caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: 10/7/1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Port Cowse — BIRTHPLACE: --
14. MOTHER'S MAIDEN NAME: Martha Burroughs — BIRTHPLACE: --

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: John C. Wells — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1551 Obstructive Jaundice Dx — INTERVAL BETWEEN ONSET AND DEATH: 11/2/67

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cancer of Liver Dx — 11/2/67
DUE TO (c) Cancer of Gall bladder Dx — 11/20/67

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Multiple Gall stones — 11/20/67

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Cancer of GB. & Liver Carcinomatosis
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/4, 1967, *to* 11/20, 1967, *that I last saw the deceased alive on* 11/20, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Everett N. Jones Md. 267 (Degree or title)
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 11/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 11/24
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State): Weiser, Idaho

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Norwell N. Demarg
LICENSE NO.: E 508

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4761
Local Reg. No. 190
Reg. Dist. No. 371

BIRTH NO.

RECEIVED NOV 27 1967 Bureau of

1. PLACE OF DEATH
a. COUNTY 011 ADA
b. CITY OR TOWN BOISE, IDAHO.
c. LENGTH OF STAY IN (this place) 88 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA Center, Boise, Idaho. 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO. b. COUNTY 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise,
d. STREET ADDRESS (If rural, give location) General Delivery, Ustick, Idaho.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Joseph	J	MAKINSON.		11	21	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	1-26-21	46				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Landscaper 21	Same	Oregon.	U S A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Makinson.	Oregon	Sophia Pratt	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Korean 7	519 16 5932	VA Hospital Records	Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 months +

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchogenic carcinoma — 10 months +
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
VA m.		

22. ~~I hereby certify that I attended the deceased from~~ 8-25 1967 to 11-21, 1967 ~~that I last saw the deceased alive on~~ and that death occurred at 8:10AM m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis M.D. 597 ROBERT C LEWIS, M.D.	VA Center, Boise, Idaho	11-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-24-67	Halfway Cemetery	Halfway, Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-27-67	Myrtle Palmer	J. Richard Reed	E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4762
Local Reg. No. 643
Reg. Dist. No. 370

BIRTH NO. RECEIVED NOV 30 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4719 Albion

3. NAME OF DECEASED (Type or Print): a. (First) Arba; b. (Middle) Allen; c. (Last) Hamilton

4. DATE OF DEATH (Month) (Day) (Year): Nov. 21, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Oct. 20, 1889

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Display dept. 25

10b. KIND OF BUSINESS OR INDUSTRY: dept. store

11. BIRTHPLACE (State or foreign country): Bartley, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William S. Hamilton — BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Mary Ann Puckett — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W.I

16. SOCIAL SECURITY NO.: 518-09-0128

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Grace E. Hamilton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardiovascular Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic pulmonary fibrosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August 24 1964, *to* November 21 1967 *that I last saw the deceased alive on* Nov 20, 1967, *and that death occurred at* 7:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): F. K. Root Jr. M.D.

23b. ADDRESS: 6003 Overland Road

23c. DATE SIGNED: 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 24, 1967

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 11-30-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Edward Palmer E-460 — LICENSE NO.

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 23 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4763
Local Reg. No. 647
Reg. Dist. No. 370

BIRTH NO. 67-10436

RECEIVED DEC 1 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada (011)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho (000)
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital (002)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada (01)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4719 Albion

3. NAME OF DECEASED (Type or Print): a. (First) Baby Girl; b. (Middle); c. (Last) Lung

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 21, 1967

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): /

8. DATE OF BIRTH: Nov. 21, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours: 4 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: no record
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Diana Lung
BIRTHPLACE: Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: X Leo R. Lung
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7835 Atelectasis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Immaturity.
DUE TO (c) Premature Delivery.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James C. Chapman, MD (089)
23b. ADDRESS: 148 E Jefferson St. Boise
23c. DATE SIGNED: 11/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-22-67
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-28-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. E. Alden
LICENSE NO.: 299
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4764
Local Reg. No. 193
Reg. Dist. No. 371

Certificate of Death

RECEIVED DEC 6 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL BOISE
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): JUN. HIGHWAY 44 & 69 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 011 ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): RURAL BOISE
d. STREET ADDRESS (If rural, give location): ROUTE 5

3. NAME OF DECEASED (Type or Print)
a. (First) DOROTHY
b. (Middle) INEZ HOLLIDAY
c. (Last) PAGE

4. DATE OF DEATH (Month) (Day) (Year): NOV. 21, 1967

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: JULY 5, 1928
9. AGE (In years last birthday): 39 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE 01
10b. KIND OF BUSINESS OR INDUSTRY: AT HOME
11. BIRTHPLACE (State or foreign country): MARTINSDALE, MONTANA
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: WILLIAM HODDIDAY — BIRTHPLACE: MONTANA
14. MOTHER'S MAIDEN NAME: VIOLETTA THOMPSON — BIRTHPLACE: MONTANA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 549-36-7583
17. INFORMANT'S OWN SIGNATURE: Elizabeth W. Kent — ADDRESS: Reno Nevada

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gun shot thru the Neck & Body — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c) Wife and Husband had been Seperated, then cut in Auto togeather. Husband shot her. then himself.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Homicide 3
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hiway 44 West 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 of Eagle. In Auto — Ada 010 — Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): II-2I-67 9 P m. 2
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Rifle shot thru body, by her husband.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 9 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris, 583 (Degree or title) Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: II-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL 1
24b. DATE: 11-24-67
24c. NAME OF CEMETERY OR CREMATORY: KOHLERLAWN CEMETERY
24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Richard L. Maus — LICENSE NO. 443
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive, and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4765
Local Reg. No. 194
Reg. Dist. No. 221

BIRTH NO.

RECEIVED DEC 6 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA Dll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL BOISE
c. LENGTH OF STAY (If outside this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) JUN. HIGHWAY 44 & 69

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY ADA Dll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE (RURAL)
d. STREET ADDRESS (If rural, give location) ROUTE 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	ALBERT	PAGE	NOV. 21, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	WIDOWED 2	JULY 15, 1928	39				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
INSTALATION 21	DRY WALL	WEWELA, SOUTH DAKOTA	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JOHN T. PAGE	IOWA	ROSE MARIE SCHRODER	IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO			X William L McDowell	Nampa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9268

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Self Inflicted gun shot thru Body. — INTERVAL BETWEEN ONSET AND DEATH: Inst;

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Husband & Wife had been seperated & then out in Auto.togeather

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. He had shot his wife, then him self. despondant.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Suicide 2	06	13 Hiway 44. west of Eagle. Idaho.

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
II 21-67 9P m.2		With a rifle, shot his wife, then him self.

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ed Paris 583	Coroner	3720 Meadow Drive. Boise.	II-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	11-24-67	KOHLER LAWN CEMETERY	NAMPA, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-4-67	Myrtle Palmer	Richard L. Ware	443

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Born
Ada Co

Certificate of Death

STATE OF IDAHO

State File No. 4766
Local Reg. No. 651
Reg. Dist. No. 370

RECEIVED
DEC 1 1967
Bureau of Vital Statistics

...rite RURAL and give ... | ...ENGTH OF STAY (in this place) 000

...l or institution, give street address or location) ...S. Arcadia 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 2114 S. Arcadia

(Type or Print) Jeffrey | b. (Middle) Leonard | c. (Last) Ghertler | 4. DATE OF DEATH (Month) Nov. (Day) 22, (Year) 1967

5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married / | 8. DATE OF BIRTH Jan. 5, 1953 | 9. AGE (In years last birthday) 14 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) student 03 | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Idaho | 12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frederick Ghertler | BIRTHPLACE New York | 14. MOTHER'S MAIDEN NAME Elizabeth Miller | BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT'S OWN SIGNATURE Frederick Ghertler | ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

201X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hodgkin's granuloma | INTERVAL BETWEEN ONSET AND DEATH 5yr 10mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. | 21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 26 Oct, 1964, *to* 22 Nov, 1967, *that I last saw the deceased alive on* 20 Nov, 1967, *and that death occurred at* 1 45 A *m., from the causes and on the date stated above.*

23a. SIGNATURE Hugh Atchley 014 (Degree or title) MD | 23b. ADDRESS 401 Idaho St Boise Ida | 23c. DATE SIGNED 29 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial / | 24b. DATE 11-27-1967 | 24c. NAME OF CEMETERY OR CREMATORY Morris Hill | 24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 11-30-67 | REGISTRAR'S SIGNATURE Myrtle Palmer | 25. EMBALMER Elach M Sears | LICENSE NO. E-460

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BL... typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF V...

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED Certificate of Death

STATE OF IDAHO

State File No. 4767
Local Reg. No. 664
Reg. Dist. No. 370

BIRTH NO.

DEC 5 1967

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho
b. COUNTY: 010 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Star
d. STREET ADDRESS (If rural, give location): Star, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Dwight c. (Last) Lenzi

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 23, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 11, 1917

9. AGE (In years last birthday): 50
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant 22

10b. KIND OF BUSINESS OR INDUSTRY: Merchant

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dwight Lenzi
BIRTHPLACE: Salt Lake City, Utah

14. MOTHER'S MAIDEN NAME: Rebecca Empey
BIRTHPLACE: Idaho Falls, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 554 09 0674

17. INFORMANT'S OWN SIGNATURE: X Virginia M. Lenzi
ADDRESS: Star, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary heart disease — several months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov. 16, 1967, *to* Nov. 23, 1967, *that I last saw the deceased alive on* Nov 22, 1967, *and that death occurred at* 1:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner 364 (Degree or title): MD

23b. ADDRESS: 105 N. 8th St. Boise, Idaho

23c. DATE SIGNED: 11/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-25-67

24c. NAME OF CEMETERY OR CREMATORY: Star Cemetery

24d. LOCATION (City, town, or county) (State): Star, Idaho

DATE REC'D BY LOCAL REG.: 12-5-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson

LICENSE NO.: E-512

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 13 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 6 1984

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 15 1993

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended Dec 4, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4768
Local Reg. No. 640
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 318 West State Street

3. NAME OF DECEASED (Type or Print): a. (First) John; b. (Middle) Moultrie; c. (Last) Ward

4. DATE OF DEATH (Month) (Day) (Year): November 23, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Nov. 8, 1899

9. AGE (In years last birthday): 68
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Publicity Officer 08

10b. KIND OF BUSINESS OR INDUSTRY: State Dept. Commerce

11. BIRTHPLACE (State or foreign country): Columbia, South Carolina

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Moultrie Ward - BIRTHPLACE: Charleston, So. Carolina

14. MOTHER'S MAIDEN NAME: Lucy Bauskett - BIRTHPLACE: Columbia, So. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WWI 3

16. SOCIAL SECURITY NO.: 082-03-9646

17. INFORMANT'S OWN SIGNATURE: Patricia H. Ward - ADDRESS: 318 W. State, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary artery heart disease — INTERVAL BETWEEN ONSET AND DEATH: pos. 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis — ?
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 Sept, 1967, *to* 23 Nov, 1967, *that I last saw the deceased alive on* 17 Nov, 1967, *and that death occurred at* 6:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold W. Hatten, Jr., M.D. 212

23b. ADDRESS: 6003 Overland, Boise, Ida.

23c. DATE SIGNED: 25 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-27-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-30-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: A. Dale McMurtrey

LICENSE NO.: E 410

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for John Moultrie Ward (Name on Original Certificate) who died (Was Born or Died) on November 23, 1967 (Date of Event)
in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Edward Joseph Calhoun (Bible Record, Insurance Policy, Etc.) prepared on November 27, 1967 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item #10A	Publicity Agent	Publicity Officer
Item #13	Unknown	Charleston, So. Carolina
Item #14	Unknown	Columbia, So. Carolina

Subscribed and sworn to before me this 4th day of December, 1967

Notary Public, residing at Boise, Idaho

My commission expires September 10, 1970

(Seal)

Signed Fred E. Walker
(Signature of parent or attendant if correcting a birth record; or attendant, funeral director, informant if correcting a death record; or other credible person.)

1205 Bannock Boise, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 4th day of December, 19 67

Notary Public, residing at Boise, Idaho

My commission expires September 10, 1970

(Seal)

Signed J. Richard Reed
(Signature of Any Credible Person)

1205 Bannock Boise, Idaho
(Street Address, City, State)

FORM DH 60-155

in office 12-4-67 no corres.

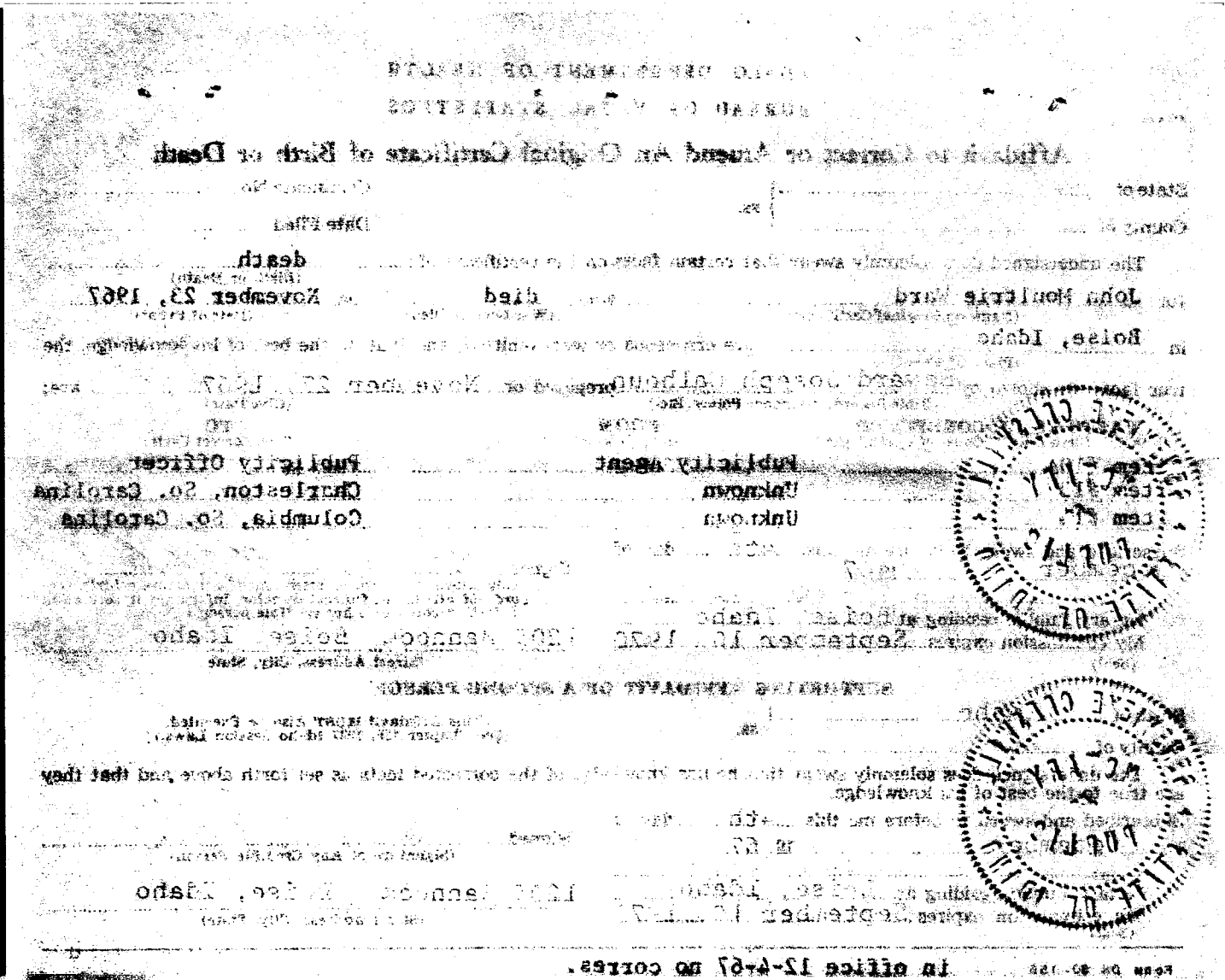

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 640
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 29 1967 Bureau of Vital Statistics DOH

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): DOH
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 318 West State Street

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): MOULTRIE
c. (Last): WARD

4. DATE OF DEATH (Month) (Day) (Year): Nov. 23, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Nov. 8, 1899

9. AGE (In years last birthday): 68
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Publicity Agent, State Dept Commerce

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Columbia, South Carolina

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Moultrie Ward
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Lucy Bauskett
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: 082-03-9646

17. INFORMANT'S OWN SIGNATURE: Patricia H. Ward
ADDRESS: 318 W. State Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary artery heart disease
INTERVAL BETWEEN ONSET AND DEATH: pos. 5 yrs. ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 25 Sept, 1967, *to* 23 Nov., 1967, *that I last saw the deceased alive on* 17 Nov., 1967, *and that death occurred at* 6:15 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold M. Slatter MD
23b. ADDRESS: 6003 Overland Boise Ida
23c. DATE SIGNED: 25 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-27-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-30-67
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: A. Dale McMurtrey
LICENSE NO.: E-410
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 30 1967

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 4 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4769
Local Reg. No. 647
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 505 So. 14th St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 505 So. 14th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Jennie
b. (Middle):
c. (Last): Turnbeaugh

4. DATE OF DEATH (Month) (Day) (Year): Nov. 23, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Jan. 21, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Scotts Bluff, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Reed — BIRTHPLACE: Unk
14. MOTHER'S MAIDEN NAME: Unk. — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S OWN SIGNATURE: Charles Barnett — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): General Advanced Arteriosclerosis expired in her sleep. — Months.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See *to* Alive, 19__, *that I last saw the deceased alive on* ____ 19__, *and that death occurred at* 1230A *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris 0583 (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise.
23c. DATE SIGNED: II-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-27-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 11-29-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature] — LICENSE NO. E-460

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 12 1979

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4770
Local Reg. No. 652
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 001 1-30
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY IN THIS PLACE: 30 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 408 East Jefferson St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 001 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 408 East Jefferson Street

3. NAME OF DECEASED (Type or Print): a. (First) PEARL b. (Middle) ELIZABETH c. (Last) HAGGETT

4. DATE OF DEATH (Month) (Day) (Year): Nov. 24, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never-married

8. DATE OF BIRTH: March 6, 1892

9. AGE (In years last birthday): 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Office work -State

10b. KIND OF BUSINESS OR INDUSTRY: Income Tax Div.

11. BIRTHPLACE (State or foreign country): Portland, Oregon

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: John Henry Haggett, Portland, Maine

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Matilda Glenn Coldwell, Ontario, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 518-07-1972

17. INFORMANT'S OWN SIGNATURE ADDRESS: Mrs. Edith M. Harlow, 314 4th St. Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis. — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) _____
DUE TO (c) Under Physican care, severe chest pains. expired in sleep. — Months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive., 19__, to 19__, *that I last saw the deceased alive on* _____ 19__, *and that death occurred at* 10:00 m. PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 583 Coroner

23b. ADDRESS: 3720 Meadow Drive, Boise.

23c. DATE SIGNED: 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-28-67

24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: 11-30-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Lowell W. Summers

LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4771
Local Reg. No. 655
Reg. Dist. No. 370

BIRTH NO.

RECEIVED NOV 30 1967 Vital Statistics Bureau of Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 01 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 217 Washington

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) Frances c. (Last) Gough

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 24, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 24, 1887

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Chipwaysfalls, Wisc.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Dennis Touhey
BIRTHPLACE: Ireland

14. MOTHER'S MAIDEN NAME: Ann Donnelly
BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-09-3752

17. INFORMANT'S OWN SIGNATURE: x Catherine F. Gough
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

154X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Rectum - Dx Nov 8, 1967 — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cirrhosis of Liver Dx — 11/15/67

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Ascites - Dx — 11/15/67

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Ascites - Cirrhosis of Liver - Rectal Ca

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11/7, 1967, to 11/24, 1967, that I last saw the deceased alive on 11/24, 1967, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE: Emmett L. Jones 367 (Degree or title) M.D.

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 11/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-28-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 11-30-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Daniel G. Gibson
LICENSE NO.: E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4772
Local Reg. No. 6
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2-03 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 805 East State Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ROSE	WEBSTER	HULL	Nov. 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Oct. 19, 1877	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	At home	Cokeville, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Constant L. Webster	New York	Nessi Jones	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	---	518-54-8363	[signature]	1317 E. 9th McMinnville, Oregon

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 4200 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 8-28, 19 67, *to* Nov 24, 19 67, *that I last saw the deceased alive on* Nov 20, 19 67, *and that death occurred at* 5:00 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Glenn E. Keller MD 520 (Degree or title)	125 S. Idaho	11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-27-67	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-30-67	Myrtle Palmer	[signature]	E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-10945
BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4773
Local Reg. No. 653
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: 55 Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kearns
d. STREET ADDRESS (If rural, give location): 4375 W 4985 S.

3. NAME OF DECEASED (Type or Print): a. (First) Lance; b. (Middle); c. (Last) Thomson

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 25, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married 1

8. DATE OF BIRTH: Nov. 23, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days: 2 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Emmett, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Bruce Thomson
BIRTHPLACE: Utah Salt Lake City

14. MOTHER'S MAIDEN NAME: Carol Larsen
BIRTHPLACE: Emmett, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: X Robert Bruce Thomson
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7767 Prematurity

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/24, 1967, *to* 11/25, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 1:50A m., *from the causes and on the date stated above.*

23a. SIGNATURE: W J Jennings 542 (Degree or title) MD

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Nov. 27. 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: 11-30-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-10946
BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4774
Local Reg. No. 654
Reg. Dist. No. 370

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: 555 Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kearns
d. STREET ADDRESS (If rural, give location): 4375 W. 4985 So.

3. NAME OF DECEASED (Type or Print): a. (First) Lane; b. (Middle); c. (Last) Thomson

4. DATE OF DEATH (Month) (Day) (Year): Nov. 25, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Nov. 23, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months: 2 Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): infant 02

10b. KIND OF BUSINESS OR INDUSTRY: ----

11. BIRTHPLACE (State or foreign country): Emmett, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Bruce Thomson — BIRTHPLACE: Salt Lake City Utah

14. MOTHER'S MAIDEN NAME: Carol Larsen — BIRTHPLACE: Emmett, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE ADDRESS: X Robert Bruce Thomson

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7768

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/24, 1967, *to* 11/25, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 5:25 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: W R Venning 542 (Degree or title) MD

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Nov. 27, 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: 11-30-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Glenn W Beatty

LICENSE NO.: E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4775
Local Reg. No. 657
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 01 — 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: 21 Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 53 East 2nd. South

3. NAME OF DECEASED (Type or Print): a. (First) Thomas — b. (Middle) ----- — c. (Last) Heath

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 25, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Jan. 22, 1894

9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.: 73

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): President 19

10b. KIND OF BUSINESS OR INDUSTRY: Sugar Co.

11. BIRTHPLACE (State or foreign country): Stafford Shire England

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Tom Heath — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Clara Parr — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: x Hugh A. Harper, Jr. — ADDRESS: 1101 N 23 344-1920

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 331X Cerebellar hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — 10 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Ca prostate

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 10, 1967, *to* Nov 25, 1967, *that I last saw the deceased alive on* Nov 25, 1967 *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): George R Baker MD

23b. ADDRESS:

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-29-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 11-30-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Daniel G. Gibson — LICENSE NO.: E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 18 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Or Hair.

Certificate of Death

STATE OF IDAHO

State File No. 4776
Local Reg. No. 648
Reg. Dist. No. 270

BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2207 Norcrest Dr.

3. NAME OF DECEASED (Type or Print): a. (First) EARL; b. (Middle) WEBSTER; c. (Last) OLSON

4. DATE OF DEATH: (Month) NOV. (Day) 26, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 3, 1903

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Manager 26

10b. KIND OF BUSINESS OR INDUSTRY: General Mills, Inc.

11. BIRTHPLACE (State or foreign country): Essex, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Olson
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME:
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mrs Earl W. Olson
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2043

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute myelocytic leukemia — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10/23, 1967, *to* 11/26, 1967, *that I last saw the deceased alive on* 11/26, 1967, *and that death occurred at* 7:25 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS:

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: 11-29-67

24c. NAME OF CEMETERY OR CREMATORY: Mountain View

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 11-29-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson
Eldon T. Pearson
LICENSE NO.: E-512

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Dec. 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4777
Local Reg. No. 300
Reg. Dist. No. 271

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 001 — 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (in this place): 39 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VA CENTER, BOISE, IDAHO 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 010
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): MERIDIAN
d. STREET ADDRESS (If rural, give location): 124 E. Pine

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM; b. (Middle) L.; c. (Last) KIMBLE

4. DATE OF DEATH: (Month) 11; (Day) 26; (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 4-14-87

9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer retired 04

10b. KIND OF BUSINESS OR INDUSTRY: same

11. BIRTHPLACE (State or foreign country): Garfield Co., Wn

12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: John G. Kimble — BIRTHPLACE: Pa.

14. MOTHER'S MAIDEN NAME: Minerva Grover — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: 573-36-1533

17. INFORMANT'S OWN SIGNATURE: R. Nora Allen — ADDRESS: VA Hospital Records, Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebrovascular accident with left hemiplegia — INTERVAL BETWEEN ONSET AND DEATH: 7 weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Atrial fibrillation — Unknown; Arteriosclerotic heart disease — Unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) VA m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ I attended the deceased from 10-18, 19 67, to 11-26-, 19 67, ~~that I last saw the deceased~~ and that death occurred at 8:40 A m., from the causes and on the date stated above.

23a. SIGNATURE: Robert C. Lewis, M.D. — ROBERT C. LEWIS, M.D. 547

23b. ADDRESS: VA Center, Boise, Idaho

23c. DATE SIGNED: 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal-Burial

24b. DATE: 11-30-67

24c. NAME OF CEMETERY OR CREMATORY: Pomroy

24d. LOCATION (City, town, or county) (State): Pomroy, Washington

DATE REC'D BY LOCAL REG.: 12-8-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Geo. Conrad — LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended January 3, 1968

Certificate of Death

STATE OF IDAHO

State File No. 4778
Local Reg. No. 642
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (in this place): 000

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA St. Alphonsus Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada 010

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Star

d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) Leonard; b. (Middle) D.; c. (Last) Ashton

4. DATE OF DEATH: (Month) (Day) (Year) November 26, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 4, 1900

9. AGE (In years last birthday): 67 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired bartender 33

10b. KIND OF BUSINESS OR INDUSTRY: beverage

11. BIRTHPLACE (State or foreign country): Monte Vista, Colorado

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: D. W. Ashton — BIRTHPLACE: Colorado

14. MOTHER'S MAIDEN NAME: Abbie Wight — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: 519-10-3404

17. INFORMANT'S OWN SIGNATURE: Louise A. Ashton — ADDRESS: Star, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary artery disease — INTERVAL BETWEEN ONSET AND DEATH: 1952

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Multiple coronary infarcts — 15 yrs.

DUE TO (c) probable terminal arrythemia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: Autopsy - Coronary artery disease

20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* seen in emergency room St. Alphonsus, *last saw the deceased alive on* DOA, 19___, *and that death occurred at* 6:15 pm., *from the causes and on the date stated above.*

23a. SIGNATURE: Everett N. Jones, M.D. 267 (Degree or title)

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 11-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-29-67

24c. NAME OF CEMETERY OR CREMATORY: Star Cemetery

24d. LOCATION (City, town, or county) (State): Star, Idaho

DATE REC'D BY LOCAL REG.: 11-30-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Fred E. Walker

LICENSE NO.: E 483

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

12-29-67

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED

JAN 3 1968

State of IDAHO } ss.
County of ADA

Certificate No. 67-4778

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death) for Leonard D. Ashton (Name on Original Certificate) who died (Was Born or Died) on Nov. 26, 1967 (Date of Event) in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by FAMILY RECORDS (Bible Record, Insurance Policy, Etc.) prepared on OR ABOUT JULY 4, 1900 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 11 Birthplace	Van Wyck, Idaho	Monte Vista, Colorado

Subscribed and sworn to before me this 29th day of December, 1967

Genevieve Creswell

Notary Public, residing at Boise

My commission expires Sept 10, 1970

(Seal)

Signed J. Richard Reed

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

906 N. 17th St - Boise Idaho

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 29th day of December, 1967

Genevieve Creswell

Notary Public, residing at Boise

My commission expires Sept 10, 1970

(Seal)

Signed Lowell N. Demaray

(Signature of Any Credible Person)

2111 Ellis Ave. Boise Idaho

(Street Address, City, State)

FORM DH 60-155

12-29-67

[redacted]

RECEIVED

JAN 3

67-4778

death

Nov. 26, 1967

Ashton died

Idaho

Monte Vista, Colorado

Van Dyck, Idaho

STATE OF IDAHO
PUBLIC
REGISTRAR CERTIFICATE

STATE OF IDAHO
PUBLIC
REGISTRAR CERTIFICATE

State File No. 4778
Local Reg. No. 642
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 30 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) ----
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street, office or location): DOA St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Star
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): LEONARD
b. (Middle): D.
c. (Last): ASHTON

4. DATE OF DEATH (Month) (Day) (Year): November 26, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married
8. DATE OF BIRTH: July 4, 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired bartender
10b. KIND OF BUSINESS OR INDUSTRY: beverage
11. BIRTHPLACE (State or foreign country): Van Wyck, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: D. W. Ashton — BIRTHPLACE: Colorado
14. MOTHER'S MAIDEN NAME: Abbie Wight — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.: 519-10-3404
17. INFORMANT'S OWN SIGNATURE: Louise A. Ashton — ADDRESS: Star, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary artery Disease — INTERVAL BETWEEN ONSET AND DEATH: 1952

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple Coronary Infarcts — 15 yrs.
DUE TO (c) Probable Terminal arrythmea

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION: autopsy - Coronary artery disease.
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 0
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 0 m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Seen in emergency Room St Alphonsus *19___, to _____, 19___, that I last saw the deceased* ✓ *alive on* DOA *, 19___, and that death occurred at* 6:15 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Everett Jones MD.
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 10/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 11-29-67
24c. NAME OF CEMETERY OR CREMATORY: Star Cemetery
24d. LOCATION (City, town, or county) (State): Star, Idaho

DATE REC'D BY LOCAL REG.: 11-30-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-483

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 30 1967

JAN 3 1968

MAR 3 1988

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4779
Local Reg. No. 665
Reg. Dist. No. 370

Certificate of Death

RECEIVED
DEC 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2027 Ellis Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): EVA
b. (Middle):
c. (Last): AUSTIN

4. DATE OF DEATH (Month) (Day) (Year): Nov. 27, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 18, 1889
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Woodruff, Indiana
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Eshelman — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Emma Hall — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-07-0406
17. INFORMANT'S OWN SIGNATURE: S. B. Austin — ADDRESS: 2027 Ellis Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

578X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Idiopathic acute necrosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): of intestines
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 36 hours

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1954, *to* death, 19__, *that I last saw the deceased alive on* Nov 27, 1967, *and that death occurred at* 11 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C K Blackburn MD 046
23b. ADDRESS: 800 La Cassia Way Boise
23c. DATE SIGNED: 30 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-30-67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-5-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4780
Local Reg. No. 658
Reg. Dist. No. 370

Certificate of Death

RECEIVED DEC 5 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): ST. LUKES HOSPITAL 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: 011 ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 1721 AMBER

3. NAME OF DECEASED (Type or Print)
a. (First): TOM
b. (Middle): C.
c. (Last): PETHICK

4. DATE OF DEATH (Month) (Day) (Year): NOV. 27, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3
8. DATE OF BIRTH: NOV. 1, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RET. SUPERVISOR 08
10b. KIND OF BUSINESS OR INDUSTRY: IDA. HIGHWAY
11. BIRTHPLACE (State or foreign country): TYLER HILL, PENN.
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CHARLES PETHICK — BIRTHPLACE: NO RECORD
14. MOTHER'S MAIDEN NAME: SARAH McINTYRE — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): W W I 3
16. SOCIAL SECURITY NO.: 529-28-4478
17. INFORMANT'S OWN SIGNATURE: Florence Pethick — ADDRESS: BOISE, 5271

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Renal insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary emphysema — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1954, *to* Nov, 1967, *that I last saw the deceased alive on* Nov 27, 1967, *and that death occurred at* 4:35A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Gary R Baker 019 (Degree or title) MD
23b. ADDRESS: BOISE, IDAHO
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 11-29-67
24c. NAME OF CEMETERY OR CREMATORY: DRY CREEK CEMETERY
24d. LOCATION (City, town, or county) (State): BOISE, IDAHO

DATE REC'D BY LOCAL REG.: 11-30-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHEPHERD MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4781
Local Reg. No. 676
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 15 1967
Bureau of Vital Statistics
STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 141 Canyon
c. CITY OR TOWN: Caldwell
d. STREET ADDRESS (If rural, give location): 715 Freeport

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	George	W.	Randolph	Nov. 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 27, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Silver Creek, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joshua A. Randolph	Kansas	Lillie May Muncey	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-36-0777A
17. INFORMANT'S OWN SIGNATURE: x Marjorie M. Linder — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pulmonary infection	1 week
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Severe malnutrition	2 months
DUE TO (c)	Esophageal obstruction	1 year
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

5391

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
16 Nov 67	Esophageal obstruction	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 15 Nov, 1967, *to* 28 Nov, 1967, *that I last saw the deceased alive on* 28 Nov, 1967, *and that death occurred at* 240 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Norman D. Lower 780 MD	312 W Idaho, Boise	6 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 1, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-11-67	Myrtle Palmer	Kenneth E Spence	E-395

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 9 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4782
Local Reg. No. 195
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CASSIA 161
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BURLEY
d. STREET ADDRESS (If rural, give location): 118 West ~~XX~~ Main

3. NAME OF DECEASED (Type or Print): a. (First) DAVID; b. (Middle) (NMI); c. (Last) BOWEN

4. DATE OF DEATH: (Month) NOV (Day) 28 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widower 2
8. DATE OF BIRTH: 2-7-92
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER 06
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John M Bowen — BIRTHPLACE: Wales
14. MOTHER'S MAIDEN NAME: Mary Densley — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): Yes (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 519 32 02 79
17. INFORMANT'S OWN SIGNATURE: D.L. Moore D.L. Moore — ADDRESS: VAC, Boise, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — 8 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ I attended the deceased from Nov. 27, 1967, to Nov 28, 1967, ~~that I last saw the deceased alive on~~, and that death occurred at 6:30 PM m., from the causes and on the date stated above.

23a. SIGNATURE: O.F. SWINDELL, M.D. 518 — (Degree or title): I
23b. ADDRESS: V.A. Center, Boise, Idaho
23c. DATE SIGNED: 11-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 11-29-67
24c. NAME OF CEMETERY OR CREMATORY: Burley
24d. LOCATION (City, town, or county) (State): Burley, Cassia, Idaho

DATE REC'D BY LOCAL REG.: 12-5-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Arden-Waggoner Chapel — LICENSE NO.: E-460
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 1 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4783
Local Reg. No. 639
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1615 N. 7th

3. NAME OF DECEASED (Type or Print)
a. (First): Edward
b. (Middle): H.
c. (Last): Lufkin

4. DATE OF DEATH (Month) (Day) (Year): Nov. 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: May 6, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): painter 21
10b. KIND OF BUSINESS OR INDUSTRY: painting
11. BIRTHPLACE (State or foreign country): Hailey, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Lufkin — BIRTHPLACE: Vermont
14. MOTHER'S MAIDEN NAME: Katherine Jones — BIRTHPLACE: Myrthatidville, Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 540-01-1951
17. INFORMANT'S OWN SIGNATURE: Lovenia L. Campbell — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: unkn

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
~~DUE TO~~ with (b): Pleural effusion + failure — 4+ wks
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Nephrosclerosis + Uremia — 4+ wks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-6, 1967, *to* 11-28, 1967, *that I last saw the deceased alive on* 11-27, 1967, *and that death occurred at* 6:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: W. D. Forney 173 (Degree or title): M.D.
23b. ADDRESS: 425 Bannock St Boise
23c. DATE SIGNED: 11-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal Burial 3
24b. DATE: 11-30-1967
24c. NAME OF CEMETERY OR CREMATORY: Rose City Cemetery
24d. LOCATION (City, town, or county) (State): Portland, Oregon

DATE REC'D BY LOCAL REG.: 11-29-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Elad M. Shears — LICENSE NO. E-460
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, General Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED

State File No. 4784
Local Reg. No. 667
Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 01 — DEC 6 1967 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 01 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 2023 Shoshone St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Lizzie	Beth	Kellogg	Nov.	28	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Divorced 4	June 29, 1887	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Same	Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Knoll	Unknown	# No Record #	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	331X	L. D. Kellogg	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) cerebral asteriosclerosis — several mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes — ??

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-27, 1967, *to* 11-28, 1967, *that I last saw the deceased alive on* 11-28, 1967, *and that death occurred at* 8:45 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Paul F. Miner 364 MD	105 N. 8th St Boise	12-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-1-67	Dry Creek Cemetery	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-5-67	Myrtle Palmer	Frank Glenn	E-460

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 2 8 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4785
Local Reg. No. 668
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 6 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Route # 5 Boise

3. NAME OF DECEASED (Type or Print)
a. (First): Kata
b. (Middle): ---
c. (Last): Koprcina

4. DATE OF DEATH: (Month) Nov. (Day) 28, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Nov. 24, 1880

9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Belovara, Austria

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: J. Bonich
BIRTHPLACE: Austria

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: Austria

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 493X

17. INFORMANT'S OWN SIGNATURE: Tony Koprcina
ADDRESS: Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Infarct
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pneumonia
DUE TO (c) -

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes -

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11-23, 1967, *to* 11-28, 1967, *that I last saw the deceased alive on* 28 Nov, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Edward D. Purcell M.D. 35 (Degree or title)

23b. ADDRESS: Twin Falls Idaho

23c. DATE SIGNED: 12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-1-67

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 12-5-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson
Eldon T. Pearson

LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Ho me

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 15 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 10 1976

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 12 1982

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4786
Local Reg. No. 796
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 Miles Cole Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Herbert b. (Middle) W. c. (Last) Wait

4. DATE OF DEATH: (Month) Nov. (Day) 28 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 24, 1913

9. AGE (In years last birthday): 53
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 54

10b. KIND OF BUSINESS OR INDUSTRY: Wait Equipment

11. BIRTHPLACE (State or foreign country): Pleasant Hill, Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Rev. C. B. Wait
BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Mina Fouts
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mrs. Herbert Wait
ADDRESS: Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 976X Self Inflicted gun shot in head. — INTERVAL BETWEEN ONSET AND DEATH: Brief.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*: Despondent, Business affairs. — Months.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 00
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19____, *that I last saw the deceased alive on* ____ 19____ *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23a. SIGNATURE: 583 E. D. Pearson (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive, Boise
23c. DATE SIGNED: 12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-2-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 12-5-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4787
Local Reg. No. 663
Reg. Dist. No. 370

RECEIVED DEC 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1711 Franklin St.

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): Guloise
c. (Last): Punnell

4. DATE OF DEATH (Month) (Day) (Year): Nov. 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 20, 1876
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Owner 22
10b. KIND OF BUSINESS OR INDUSTRY: Punnell Variety
11. BIRTHPLACE (State or foreign country): Lansing, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Peter Punnell — BIRTHPLACE: Luxenburg
14. MOTHER'S MAIDEN NAME: Cecelia Trayer — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 476-28-0163
17. INFORMANT'S OWN SIGNATURE: Mrs. William Punnell — ADDRESS: Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio Respiratory Failure

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) ASHD

DUE TO (c) Prostatic obstruction infection

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14, 1967, *to* 11-28, 1967, *that I last saw the deceased alive on* 11-17, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gerald M. Hecht M.D. 221
23b. ADDRESS: 403 Idaho
23c. DATE SIGNED: 11-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-1-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 10 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4788
Local Reg. No. 688
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 01 — c. LENGTH OF STAY (in this place): 1 day
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — 3-01
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Montana 27 — b. COUNTY: 555 Hamilton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ravalli
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	J A Y	F.	GIBBS	Nov. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
male	white	widowed 07	March 30, 1879	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
rancher (retired) 04		Polk Co., North Carolina	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Gibbs	No. Carolina	Amanda Mc Murray	No. Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		UNKNOWN	Lee Gibbs	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

490X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bilateral pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov. 28, 1967 *to* Nov. 29, 1967, *that I last saw the deceased alive on* Nov. 29, 1967, *and that death occurred at* 1:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (364)	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul F. Miner	MD	1057 N. 8th St. Boise, Idaho	12/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal to	12-23-67 Hamilton, Montana	Hamilton	Hamilton, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-13-67	Myrtle Palmer	Conway Grant	E478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 29 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 18 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town, and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4789
Local Reg. No. 697
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 22 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convelesent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 421 T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 429 4th Street North

3. NAME OF DECEASED (Type or Print)
a. (First): MYRTLE
b. (Middle): A.
c. (Last): LONG

4. DATE OF DEATH (Month) (Day) (Year): November 29, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 3, 1879
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Peru, Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Rowilsin — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Rhoda Sleight — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-09-4207
17. INFORMANT'S OWN SIGNATURE: Dr Mae Beam — ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 1) ASHD & 2) CVA — INTERVAL BETWEEN ONSET AND DEATH: 1) ? 2) 1wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized As
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 26 Sept., 1962, *to* 11/29/, 1967, *that I last saw the deceased alive on* 24 Nov., 1967, *and that death occurred at* 12:30pm., *from the causes and on the date stated above.*

23a. SIGNATURE: Sh. Statten 212 — (Degree or title): M.D. 1
23b. ADDRESS: 6003 Overland Boise
23c. DATE SIGNED: 12 Dec. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 12/2/67
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 12-21-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4790
Local Reg. No. 670
Reg. Dist. No. 370

RECEIVED DEC 6 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 3-11
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 3502 Meadow Drive

3. NAME OF DECEASED (Type or Print) a. (First) JESS b. (Middle) W. c. (Last) BELKNAP

4. DATE OF DEATH (Month) (Day) (Year) Nov. 30, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 23, 1899

9. AGE (In years last birthday) 68 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer

10b. KIND OF BUSINESS OR INDUSTRY 09 M.S. Telephone Co.

11. BIRTHPLACE (State or foreign country) Dakota City, So. Dakota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles T. Belknap BIRTHPLACE Wisconsin

14. MOTHER'S MAIDEN NAME Bertha L. Smith BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. #1

16. SOCIAL SECURITY NO. 518-07-2031A

17. INFORMANT'S OWN SIGNATURE Mrs. LaBelle R. Belknap ADDRESS 3502 Meadow Dr.

4200

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Failure — INTERVAL BETWEEN ONSET AND DEATH 3/1/62

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 3
DUE TO (c) Generalized arteriosclerosis — 25 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. —
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* 6/16, 1943, *to* 11/30, 1967, *that I last saw the deceased alive on* 11/30, 1967, *and that death occurred at* 11 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 421 M.D.
23b. ADDRESS Boise
23c. DATE SIGNED 12/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/2/67
24c. NAME OF CEMETERY OR CREMATORY Terrace Lawn
24d. LOCATION (City, town, or county) (State) Boise, Ada, Idaho

DATE REC'D BY LOCAL REG. 12-6-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER
LICENSE NO. E-483
FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED.. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4791
Local Reg. No. 204
Reg. Dist. No. 871

BIRTH NO.

DEC 22 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 10 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: IDAHO
b. COUNTY: 141 CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CALDWELL
d. STREET ADDRESS (If rural, give location): 414 Galveston St

3. NAME OF DECEASED (Type or Print): a. (First) JIMMIE b. (Middle) (NMI) c. (Last) ROQUEMORE

4. DATE OF DEATH: (Month) Nov. (Day) 30, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Negro	Separated 4	12-7-23	44		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): COMMON LABORER 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): LONGVIEW, TEXAS
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: SIMON ROQUEMORE — BIRTHPLACE: TEXAS
14. MOTHER'S MAIDEN NAME: BETTY COOPER — BIRTHPLACE: TEXAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 455 28 4 58 39
17. INFORMANT'S OWN SIGNATURE: D.L. MOORE — ADDRESS: VA CENTER, BOISE, IDAHO

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Malignant hypertension	2 mos.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Dissecting aortic aneurysm	2 mos.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Syphilis	25 yrs.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ I attended the deceased from 11-20-67, 19___, to 11-30-67, 19___, ~~that I last saw the deceased alive on~~, and that death occurred at 1:00 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
GLENN Q VOYLES, M.D. 544	VAC, BOISE, IDAHO	12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	12-6-67	Willamette Mt. Cemetery	Portland	Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-20-67	Myrtle Palmer	Conway Grant	E478

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAY 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4792
Local Reg. No. 22
Reg. Dist. No. 300

BIRTH NO.

DEC 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Adams 020
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Council Community Hospital 014

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Adams 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print)
a. (First): LULA
b. (Middle): PEARL
c. (Last): WALTERS

4. DATE OF DEATH (Month) (Day) (Year): Nov. 27, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced 4
8. DATE OF BIRTH: May 20, 1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own home
11. BIRTHPLACE (State or foreign country): Indian Valley, Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Joseph Burger — BIRTHPLACE: ----
14. MOTHER'S MAIDEN NAME: May Magenta Coriell — BIRTHPLACE: New York State

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Esme Tun Walters — ADDRESS: Council, Ida.

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 0.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-10, 19 67, *to* 11-27, 19 67, *that I last saw the deceased alive on* 11-27-67 19, *and that death occurred at* 4:10p *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 154 (Degree or title)
23b. ADDRESS: Council, Idaho
23c. DATE SIGNED: 12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY: Indian Valley, Cemetery
24d. LOCATION (City, town, or county) (State): Indian Valley Idaho

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Marshall L. Dickerson Jr.
LICENSE NO.: E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4793
Local Reg. No. 300
Reg. Dist. No. 21

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams 020 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 020 Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Council
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Isaac	W.	Cornett	11	28	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	caucasian	widowed 2	12/21/1879	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
rancher 04	own ranch	Benton County, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jacob Cornett	----	Ann Keyes	----------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			† Edna Moritz	Council

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, *19*____, *to* _____, *19*____, *that I last saw the deceased* dead *alive on* 11-28, *19* 67, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harold W. Slater 583	Adams Co. Coroner	Council, Idaho	12-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	12/2/67	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-2-67		† Dee Thomason	E 388

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME:

DUTIES: MAY 9 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4794
Local Reg. No. 301
Reg. Dist. No. 511

Certificate of Death

RECEIVED
NOV 9 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 030 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCammon
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 030 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCammon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): SIDNEY
b. (Middle): ARIEL
c. (Last): DOPP

4. DATE OF DEATH (Month) (Day) (Year): Nov. 1, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 27, 1938
9. AGE (In years last birthday): 29 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction 11
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ariel James Dopp — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Thelda Orchard — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1956-1958 7
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Sandra McDopp — ADDRESS: McCammon Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

981X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) GUN-SHOT Wound, Neck. All major Blood vessels of neck penetrated + torn.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Immed.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ~~ACCIDENT SUICIDE~~ HOMICIDE (Specify): Homicide 3
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 00
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 000 (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? 13

22. *I hereby certify that I attended the deceased from* ——, 19__ *to* ——, 19__, *that I ~~last~~ saw the deceased* dead *on* 11-1-, 1967, *and that death occurred at* 8:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Burton H John 583 (Degree or title): Coroner 4
23b. ADDRESS: Bannock Co. Ida
23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Nov. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: McCammon Cemetery
24d. LOCATION (City, town, or county) (State): McCammon, Bannock, Idaho

DATE REC'D BY LOCAL REG.: NOV 6 1967
REGISTRAR'S SIGNATURE: Gloria Dopata
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 14 1967

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4795
Local Reg. No. 304
Reg. Dist. No. 511

Certificate of Death

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 030 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 030 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): DAISY
b. (Middle): INGA
c. (Last): SHAY

4. DATE OF DEATH (Month) (Day) (Year): Nov. 2, 1967

5. SEX: Female
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Lemhi, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leon Inga — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Julia U. Shay — ADDRESS: Fort Hall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

151X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized Carcinomatosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma Stomach
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: ABOUT 3 Mo.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Ft Hall Bannock Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas Stevens 584 MD.
23b. ADDRESS: Ft Hall Idaho
23c. DATE SIGNED: 11/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sand Hills Cemetery
24d. LOCATION (City, town, or county) (State): Fort Hall, Idaho

DATE REC'D BY LOCAL REG.: NOV 7 1967
REGISTRAR'S SIGNATURE: Gloria Dopila
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4796
Local Reg. No. 303
Reg. Dist. No. 511

BIRTH NO.

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031 — 3-02
b. CITY OR TOWN: Pocatello
c. LENGTH OF STAY IN this place: 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony's Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) DERWOOD b. (Middle) c. (Last) READER

4. DATE OF DEATH (Month) (Day) (Year): November 2 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: August 29, 1925
9. AGE (In years last birthday): 42 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Floor covering Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: Floor covering
11. BIRTHPLACE (State or foreign country): Logan, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank R. Reader — BIRTHPLACE: Wellsville, Utah
14. MOTHER'S MAIDEN NAME: Lillie Speth — BIRTHPLACE: Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-28-9442
17. INFORMANT'S OWN SIGNATURE: Mrs. Derwood Reader — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 2, 1967, *to* Nov 2, 1967, *that I last saw the deceased alive on* Nov 2, 1967, *and that death occurred at* 8:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 009 (Degree or title) M.D.,
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Nov 6,67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 6,67
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: NOV 9 1967
REGISTRAR'S SIGNATURE: Gloria Donta
25. EMBALMER: C. Dean Hill — LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 16 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4797
Local Reg. No. 305
Reg. Dist. No. 510

Certificate of Death

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1120 South Fourth Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): MARTHA
b. (Middle): LOUISE
c. (Last): CHOULES

4. DATE OF DEATH (Month) (Day) (Year): Nov. 3, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED. (Specify): Never married
8. DATE OF BIRTH: Aug. 6, 1929
9. AGE (In years last birthday): 38 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Telephone Operator
10b. KIND OF BUSINESS OR INDUSTRY: Telephone Co.
11. BIRTHPLACE (State or foreign country): Fairview, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Elmer Choules 09 — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Irene Oliverson — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: 518 32 4765
17. INFORMANT'S OWN SIGNATURE: Elmer Choules — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9210

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration of Vomitus — INTERVAL BETWEEN ONSET AND DEATH: Stat

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Unknown
DUE TO (c) Unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 03-11, 1967, *to* 03-11, 1967, *that I last saw the deceased alive on* Did Not see pt. alive, 19__, *and that death occurred at* 9 pm., *from the causes and on the date stated above.*

23a. SIGNATURE: M.J.Sharp M.D. 465 (Degree or title) VB
23b. ADDRESS: 5th & Center, Pocatello, Idaho
23c. DATE SIGNED: 11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
24d. LOCATION (City, town, or county) (State): Fairview, Idaho

DATE REC'D BY LOCAL: NOV 9 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashby — LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4798
Local Reg. No. 366
Reg. Dist. No. 510

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 1 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hosp. 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1111 No. Harrison

3. NAME OF DECEASED (Type or Print)
a. (First): MAUDE
b. (Middle): ELIZABETH HOLDER
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Nov. 3, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 2, 1883
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Williams — BIRTHPLACE: Wales, Gt. Britain
14. MOTHER'S MAIDEN NAME: Frances Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: William W. Holder — ADDRESS: Hollister, Calif.

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerotic heart disease — with Cardio-Renal failure with
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypo natremia & chloremia —
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Small Bowel ileus & Possible obstruction, with distension & vomiting —

INTERVAL BETWEEN ONSET AND DEATH: 4 Days — 3 days —

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-1-67, 19__, *to* 11-3-67, 19__, *that I last saw the deceased alive on* 11-3-67, 19__, *and that death occurred at* 1 P *m., from the causes and on the date stated above.*

23a. SIGNATURE 362 (Degree or title): D C Miller, M.D.
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 11-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-6-67
24c. NAME OF CEMETERY OR CREMATORY: Mount Moriah Cem.
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: NOV 13 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: John P. Gannon
LICENSE NO.: E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

REC[illegible]ED

Certificate of Death

STATE OF IDAHO

State File No. 4799
Local Reg. No. 308
Reg. Dist. No. 510

BIRTH NO.

NOV 21 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 357 North 5th Avenue

3. NAME OF DECEASED (Type or Print): a. (First) HATTIE b. (Middle) *** c. (Last) RUSSELL

4. DATE OF DEATH: (Month) November (Day) 3 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: March 27, 1889

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Maysfield Texas

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: George Gooden — BIRTHPLACE: Maysfield, Texas

14. MOTHER'S MAIDEN NAME: Molly Brewster — BIRTHPLACE: Maysfield, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 260-07-0769D

17. INFORMANT'S OWN SIGNATURE: Jeff McCully — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriosclerotic Vascular Disease — 20 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 20, *1967, to* Nov. 3, *1967, that I last saw the deceased alive on* Nov. 3, *1967, and that death occurred at* 3:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: 158 (Degree or title) — **23b. ADDRESS**: Pocatello, Idaho — **23c. DATE SIGNED**: Nov. 6, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Nov. 6, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Mountainview Cemetery — **24d. LOCATION** (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: NOV 20 1967 — REGISTRAR'S SIGNATURE: [illegible] — **25. EMBALMER**: [illegible] — LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4800
Local Reg. No. 309
Reg. Dist. No. 510

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 NOV 15 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (If not in place): Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 227 West Sherman

3. NAME OF DECEASED (Type or Print)
a. (First): NINA
b. (Middle): MARIE
c. (Last): HECTOR

4. DATE OF DEATH (Month) (Day) (Year): Nov. 5, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Mar. 23, 1906
9. AGE (In years last birthday): 61 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Wisconsin,
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Gilbert Forge
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Carrie Etta Maston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: 518 30 4240
17. INFORMANT'S OWN SIGNATURE: Vera H. Young — ADDRESS: 11 Doris Ave. Novato, Ca. 94947

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertensive cardiovascular disease — sev. yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 9, 1959, *to* Nov. 5, 1967, *that I last saw the deceased alive on* Nov. 5, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. S. Call, MD 077
23b. ADDRESS: P. O. Box 852
23c. DATE SIGNED: 11-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Nov. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: NOV 14 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Dalby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4801
Local Reg. No. 307
Reg. Dist. No. 510

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, give RURAL and township): Pocatello
LENGTH OF STAY (in this place): 1 day 30'
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 1071 Renee

3. NAME OF DECEASED (Type or Print): a. (First) MARLEN b. (Middle) JAMES c. (Last) WATTS

4. DATE OF DEATH: (Month) Nov. (Day) 8 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Aug. 28, 1904

9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cyclery shop 30

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Norton, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James A. Watts — BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Bertha LeCount — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-36-3667

17. INFORMANT'S OWN SIGNATURE: M. D. Watts — ADDRESS: Pocatello Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 1 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Chronic Asthma — 30 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan, 1966 *to* Nov 8, 1967, *that I last saw the deceased alive on* 11-8, 1967 *and that death occurred at* 10 AM *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 158 (Degree or title): MD

23b. ADDRESS: 322 Jefferson Pocatello

23c. DATE SIGNED: 11-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10 Nov 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: NOV 13 1967

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: John R Downard — LICENSE NO.: E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Amended November 29, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4802
Local Reg. No. 310
Reg. Dist. No. 510

~~BIRTH NO.~~

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 375 Washington

3. NAME OF DECEASED (Type or Print): a. (First) Roger; b. (Middle) J.; c. (Last) Todd

4. DATE OF DEATH: (Month) (Day) (Year): November 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Nov. 20, 1902

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 10

10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.

11. BIRTHPLACE (State or foreign country): Todd, North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles P. Todd
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME:
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Joe B. Todd
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4331

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: 20 mins.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Uncertain
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
inoperable carcinoma of tongue & involvement of carotid sheath on left side

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11-4, 19 67, *to* 11-9, 19 67, *that I last saw the deceased alive on* 11-9, 19 67, *and that death occurred at* 10:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Michael Worona, M.D. 774

23b. ADDRESS: Box 852 Kasiska Bldg.

23c. DATE SIGNED: 11-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov 13, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview cemetery

24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: 11-14-67

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: F. B. Ashley

LICENSE NO.: E 418

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Manning Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

State of Idaho
County of Bannock } ss.

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Roger J. Todd (Name on Original Certificate) who died (Was Born or Died) on Nov. 9, 1967 (Date of Event)
in Pocatello, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Date of Birth	Nov 20, 1901	Nov 20, 1902
Age	65	64

Subscribed and sworn to before me this 24th day of November 1967

Notary Public, residing at Pocatello, Idaho
My commission expires Dec 24, 1970
(Seal)

Signed
(Signature of parent or attendant if correcting a birth record of attendant, funeral director, informant if correcting a death record; or other credible person.)

Joe Dwight - Pocatello, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Bannock } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 24th day of November, 1967

Notary Public, residing at Pocatello, Idaho
My commission expires Dec. 24, 1970
(Seal)

Signed
(Signature of Any Credible Person)

1236 Clark Pocatello, Idaho
(Street Address, City, State)

FORM DH 60-155

11-21-67

Affidavit to Correct or Amend an Original Certificate of Birth or Death

Death

Roger J. Todd died Nov. 9, 1967

Pocatello, Idaho

Date of Birth Nov 20, 1901 Nov 20, 1902

65 64

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 310
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 375 Washington

3. NAME OF DECEASED (Type or Print)
a. (First): ROGER
b. (Middle): J.
c. (Last): TODD

4. DATE OF DEATH (Month) (Day) (Year): Nov. 9, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Nov. 20, 1901
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Todd, North Carolina
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles P. Todd — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Joe B. Todd — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cardiac Arrhythmia.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Uncertain.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Inoperable Carcinoma of tongue c̄ involvement of Carotid sheath on Left side.

INTERVAL BETWEEN ONSET AND DEATH: 20 mins.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/4, 1967, *to* 11/9, 1967, *that I last saw the deceased alive on* 11/9, 1967, *and that death occurred at* 10:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Michael Wonona MD
23b. ADDRESS: Box 852 Kusiska Bldg
23c. DATE SIGNED: 11/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: NOV 14 1967
REGISTRAR'S SIGNATURE: Gloria Dorsite
25. EMBALMER: [signature]
LICENSE NO.: E416

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Manning Funeral Chapel

DUTIES:

NOV 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 16 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 4 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4803
Local Reg. No. 319
Reg. Dist. No. 510

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 1335 South Fourth Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): GORDON
b. (Middle): KINGSLEY 018
c. (Last): STEDTFELD

4. DATE OF DEATH (Month) (Day) (Year): Nov. 16, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 9, 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Restaurant Owner and Operator
10b. KIND OF BUSINESS OR INDUSTRY: 22
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frederic Stedtfeld — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Pauline — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): xx
16. SOCIAL SECURITY NO.: 519 07 1554A
17. INFORMANT'S OWN SIGNATURE: Robert G. Stedtfeld — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9039

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Surgery for fracture of left humerus

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic Alcoholism

INTERVAL BETWEEN ONSET AND DEATH: 11-12-67 to 11-16-67

19a. DATE OF OPERATION: 11-12-67
19b. MAJOR FINDINGS OF OPERATION: Fracture of surgical neck of left humerus with open reduction and internal fixation with Rush Rod.
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 00
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11 9 1967 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Secondary to fall

22. *I hereby certify that I attended the deceased from* 11-12-67, 19__, *to* 11-16-67, 19__, *that I last saw the deceased alive on* 11-15-67, 19__, *and that death occurred at* 2:05 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard B. Gilsheim MD 745
23b. ADDRESS: 1352 E Center Pocatello
23c. DATE SIGNED: 11-27

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: NOV 30 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Dalley
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to—

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4804
Local Reg. No. 313
Reg. Dist. No. 511

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 031 Bannock — NOV 21 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 0-00

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05 b. COUNTY: Los Angeles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Maywood 55S
d. STREET ADDRESS (If rural, give location): 6105 Walker Avenue

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital

3. NAME OF DECEASED (Type or Print): a. (First) WALTER b. (Middle) M. 019 c. (Last) COLLINS

4. DATE OF DEATH (Month) (Day) (Year): November 16 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	April 21, 1889	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Professional Gardener	21 Self-employed	Hannibal, Missouri	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Hendery Collins	Illinois	Laura Dowell	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	*****	555-42-8210	Emma Collins	Maywood, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage (Stroke) — INTERVAL BETWEEN ONSET AND DEATH: D. O. A.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from xxxxxxxxxx, xxxxxxxxxx, that I last saw the deceased alive on* Nov. 16 *, 19* 67 *and that death occurred at* 6:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Burton Dotson	583 Bannock County Coroner	Pocatello, Idaho	Nov. 17, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Nov. 18, 1967		Maywood, California

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 17 1967	Elouise Dostie	Jack Henderson	E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

DUTIES:

NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4805
Local Reg. No. 314
Reg. Dist. No. 510

Certificate of Death

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 031
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 444 South 11th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): GRACE
b. (Middle): 294
c. (Last): GROUTAGE

4. DATE OF DEATH (Month) (Day) (Year): Nov. 17, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Mar. 25, 1891
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: Public schools
11. BIRTHPLACE (State or foreign country): Clarks, Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME BIRTHPLACE: George Wyman
14. MOTHER'S MAIDEN NAME BIRTHPLACE: Cora Lloyd

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE ADDRESS: Jack F. Grant Dagel

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive heart Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Atherosclerosis

INTERVAL BETWEEN ONSET AND DEATH: Approx 2 wks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9, 1967, *to* 11-17, 1967, *that I last saw the deceased alive on* 11-4, 1967, *and that death occurred at* 5:00 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Michael Wonna MD 774
23b. ADDRESS: Box 852 Pocatello
23c. DATE SIGNED: 11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Fort Logan Natl. Cem.
24d. LOCATION (City, town, or county) (State): Denver, Colorado

DATE REC'D BY LOCAL REG.: NOV 24 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4806
Local Reg. No. 379
Reg. Dist. No. 510

RECEIVED NOV 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Bannock Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 74 Valleyview Drive

3. NAME OF DECEASED (Type or Print): a. (First) STELLA b. (Middle) S. c. (Last) FLANDRO

4. DATE OF DEATH (Month) (Day) (Year): Nov. 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	July 17, 1908	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Vice Pres. 26	Auto Dealership	Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Carl Axel Soderberg	Sweden	Maria Carlstrom	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		C. Ed Flandro	Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: sev. yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* January 21, 1964, *to* Nov. 15, 1967, *that I last saw the deceased alive on* Nov. 15, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
077 S.Call,M.D.	P. O. Box 852 Pocatello	11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-21-67	Restlawn Mem. Gardens	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 28 1967	Gloria Dopita	John P. Gammon	E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 8 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4807
Local Reg. No. 315
Reg. Dist. No. 512

RECEIVED NOV 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 031 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello 031
d. STREET ADDRESS (If rural, give location) So. 15th Bannock County Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First) Joseph
b. (Middle) 018 Webster
c. (Last) Cathey

4. DATE OF DEATH (Month) (Day) (Year) Nov. 17, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH May 16, 1879

9. AGE (In years last birthday) 88
IF UNDER 1 YEAR: Months 6 Days 1
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RR Eng'r. Steam Pl.Operator

10b. KIND OF BUSINESS OR INDUSTRY 10 Railroad

11. BIRTHPLACE (State or foreign country) Waynesville, N. Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Webster Cathey BIRTHPLACE Waynesville, N. C.

14. MOTHER'S MAIDEN NAME Altha Carolina Hartgrove BIRTHPLACE Waynesville, N.C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-09-9497A

17. INFORMANT'S OWN SIGNATURE Wayne M. Cathey ADDRESS Rt #2, Blackfoot

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4500 Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 4y

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Anemia due to bleeding — 10 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 Nv, 1965, *to* 17 Nv, 1967, *that I last saw the deceased alive on* 17 Nv 17, 1967, *and that death occurred at* 12:55 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 113 (Degree or title) M.D. 1

23b. ADDRESS 804 E.Center, Pocatello, Idaho

23c. DATE SIGNED 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-20-67

24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery

24d. LOCATION (City, town, or county) (State) Pocatello, Idaho

DATE REC'D BY LOCAL REG. NOV 24 1967

REGISTRAR'S SIGNATURE Gloria Deputy

25. EMBALMER Howard Packham LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 10 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED.
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4808
Local Reg. No. 320
Reg. Dist. No. 511

RECEIVED DEC 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannack 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 1 month 2-01
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall 060
d. STREET ADDRESS (If rural, give location): Ft. Hall reservation

3. NAME OF DECEASED (Type or Print)
a. (First): MARTHA
b. (Middle): LeCLAIR
c. (Last): PAHVITSE McGILL

4. DATE OF DEATH (Month) (Day) (Year): November 18, 1967

5. SEX: Female
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Feb 22, 1917
9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Ft. Hall, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Louis LeClair — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Ah-No Gunn — BIRTHPLACE: Ft. Hall, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Marinda Mandersen — ADDRESS: Ft. Hall, Idaho

18. CAUSE OF DEATH 260X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: recent

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes Mellitus with
DUE TO (c) Kimmelstiel-Wilson syndrome

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to* Nov 18, *19*67, *that I last saw the deceased alive on* Nov 18, *19*67, *and that death occurred at* 10:00 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE 077 L.S.Cal M.D. (Degree or title)
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Nov 21,67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov 22,67
24c. NAME OF CEMETERY OR CREMATORY: Episcopal cemetery
24d. LOCATION (City, town, or county) (State): Ft. Hall Idaho

DATE REC'D BY LOCAL REG.: DEC 4 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: C. Dean Hill
LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4809
Local Reg. No. 316
Reg. Dist. No. 5-0

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 27 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): River View Apts.

3. NAME OF DECEASED (Type or Print)
a. (First): SAMUEL
b. (Middle): WILLIAM 018
c. (Last): CORDELL

4. DATE OF DEATH (Month) (Day) (Year): Nov. 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: Oct. 18, 1916
9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cement Finisher
10b. KIND OF BUSINESS OR INDUSTRY: 21 Cement
11. BIRTHPLACE (State or foreign country): Watonga, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jess Cordell — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Mable Southerland — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: 446 05 0839
17. INFORMANT'S OWN SIGNATURE: Irwin Cordell — ADDRESS: Downey, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Basal artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 72 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic CVD — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-15, 1967, *to* 11-18, 1967 *that I last saw the deceased alive on* 11-18, 1967, *and that death occurred at* 10:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 158 1
23b. ADDRESS
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: NOV 24 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashley — LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 9 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 18 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 4 [illegible]

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4810
Local Reg. No. 321
Reg. Dist. No. 510

Certificate of Death

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 838 West Bridger

3. NAME OF DECEASED (Type or Print)
a. (First): BESSIE
b. (Middle):
c. (Last): MARLEY

4. DATE OF DEATH (Month) (Day) (Year): Nov. 19, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Aug. 24, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Smithfield, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walter Henry White — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Annie Elizabeth Thornley — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Wilford Raymond Marley — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

593X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Glomerulonephritis — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 26, 1960, *to* Nov. 13, 1967, *that I last saw the deceased alive on* Nov. 13, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L. S. Call, M.D. 077
23b. ADDRESS: P. O. Box 852 Pocatello
23c. DATE SIGNED: 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: DEC 4 1967
REGISTRAR'S SIGNATURE: Glorea Dopita
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 21 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 19 1996

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4811
Local Reg. No. 318
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031 NOV 29 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
Bureau of Vital Statistics
LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 920 West Clark Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello 031
d. STREET ADDRESS (If rural, give location) 920 West Clark Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
SPENCER	R.	HERRIDGE	November 21, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 13, 1907	60				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Battalion Chief 08	City Fire Department	Salt Lake City, Utah	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Ernest Herridge		Alice Thompson	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	*****	712-09-1386	Jack L. Herridge	Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Heart Attack	unknown
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

4344

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* [illegible] *that I last saw the deceased alive on* Nov. 21, 19 67, *and that death occurred at* about 5 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
583 (Degree or title)	Bannock County Coroner, Pocatello, Idaho	Nov. 24, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 24, 1967	Mountainview Cemetery	Pocatello Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 28 1967	Gloria Dopita	Jack Henderson	E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

DUTIES:

NOV 30 1967

DEC 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 6 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4812
Local Reg. No. 331
Reg. Dist. No. 510

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY 031 Bannock DEC 11 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello Bureau of Vital Statistics
c. LENGTH OF STAY (In this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 225 W. Bridger 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 031 Pocatello
d. STREET ADDRESS (If rural, give location) 225 W. Bridger

3. NAME OF DECEASED (Type or Print)
a. (First) JACOB
b. (Middle) S.
c. (Last) DENNY

4. DATE OF DEATH (Month) (Day) (Year) Nov. 21, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Aug. 14, 1916
9. AGE (In years last birthday) 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Cassie C. Denny — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Lucille Garver — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Douglas Deny — ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Attack, Apparent.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased* Death *alive on* 11-21, 1967, *and that death occurred at* 2 *m., from the causes and on the date stated above.*

23a. SIGNATURE Burton H. John 583 (Degree or title) Coroner 4
23b. ADDRESS Bannock Co. Idaho
23c. DATE SIGNED 12-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-25-67
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cem.
24d. LOCATION (City, town, or county) (State) Pocatello, Idaho

DATE REC'D BY LOCAL REG. DEC 7 1967
REGISTRAR'S SIGNATURE Gloria Dopita
25. EMBALMER John P. Grosser — LICENSE NO. E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 18 1982

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4813
Local Reg. No. 322
Reg. Dist. No. 511

Certificate of Death

STATE OF IDAHO

RECEIVED
031 DEC 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LIMITS OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nounan 040
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): 294
c. (Last): WUTHRICH

4. DATE OF DEATH (Month) (Day) (Year): Nov. 21, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Nov. 16, 1891
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Montpelier, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Wuthrich — BIRTHPLACE: Switzerland
14. MOTHER'S MAIDEN NAME: Mary Grunig — BIRTHPLACE: Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: 518 28 3786A
17. INFORMANT'S OWN SIGNATURE: Ella Mae Wall — ADDRESS: Rupert, Idaho

18. CAUSE OF DEATH 4500
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Multiple bed sores — 2 mo

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1967, *to* 21 Nov, 1967, *that I last saw the deceased alive on* 20 Nov, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. Randall MD 113 — **23b. ADDRESS**: Pocatello Idaho — **23c. DATE SIGNED**: Nov 27 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 24, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: NOV 30 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. [signature] — LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 13 1983

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4814
Local Reg. No. 323
Reg. Dist. No. 510

RECEIVED
Bureau of Vital Statistics
DEC 5 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN: Pocatello
c. LENGTH OF STAY (In this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION: Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 855 South Harrison

3. NAME OF DECEASED (Type or Print)
a. (First): EVA
b. (Middle): MARIE 018
c. (Last): BEEBE

4. DATE OF DEATH: Nov. 23, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 20, 1909

9. AGE (In years last birthday): 57
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Basalt, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hans Carl Gregerson
BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Anna Marie Anderson
BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Irvan E. Beebe
ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1967

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis with generalized metastases — INTERVAL BETWEEN ONSET AND DEATH: 5 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Melano-carcinoma left leg — 3 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: last time 9-19-67

19b. MAJOR FINDINGS OF OPERATION: As above

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-3, 1965, *to* 11-23, 1967, *that I last saw the deceased alive on* 11-23, 19 67 *and that death occurred at* 11:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Irvan E. Beebe M.D. 187 1
(Degree or title)

23b. ADDRESS: 1448 East Center Pocatello, Idaho

23c. DATE SIGNED: 11-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY: Basalt Cemetery

24d. LOCATION (City, town, or county) (State): Basalt, Idaho

DATE REC'D BY LOCAL REG.: DEC 4 1967

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: F. B. Wilson
LICENSE NO.: E418

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4815
Local Reg. No. 324
Reg. Dist. No. 510

BIRTH NO.

DEC 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1257 East Center Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 1257 East Center Street

3. NAME OF DECEASED (Type or Print): a. (First) TED; b. (Middle) F. 000; c. (Last) BURGESS

4. DATE OF DEATH: (Month) November (Day) 24 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: December 15, 1908

9. AGE (In years last birthday): 58
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Postal Clerk 68

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Post Office

11. BIRTHPLACE (State or foreign country): Shoshone Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Charles U. Burgess
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Cassie Edna Kenaston
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.: 518-09-9415

17. INFORMANT'S OWN SIGNATURE: Mrs. E. E. Burgess ADDRESS: Pocatello, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of the stomach with generalized metastases — INTERVAL BETWEEN ONSET AND DEATH: app. 4 mn.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Above lesion described at the time of abdominal exploration on October 17, 1967.

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug. 15, 1967, *to* Nov. 24, 1967, *that I last saw the deceased alive on* Nov. 24, 1967, *and that death occurred at* 9:20a m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. E. Comstock M.D. (Degree or title): J.E. Comstock, M.D.

23b. ADDRESS: Pocatello, Idaho

23c. DATE SIGNED: Nov. 27, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 27, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: DEC 4 1967

REGISTRAR'S SIGNATURE: Gloria Downs

25. EMBALMER: Jack Henderson — LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4816
Local Reg. No. 325
Reg. Dist. No. 510

BIRTH NO.

DEC 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 0-∞
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA Bannock Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 101 Ravine Drive

3. NAME OF DECEASED (Type or Print): a. (First) OSCAR b. (Middle) A. 000 c. (Last) RILEY, JR.

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 10, 1922
9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Timekeeper 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Brigham City, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oscar A. Riley — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Ethel Lambert — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: 4201
17. INFORMANT'S OWN SIGNATURE: Mrs. O. A. Riley, Jr. ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~, 19___, *to* ~, 19___, *that I last saw the deceased alive on* 11-25, 1967, *and that death occurred at* 11:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 583 (Degree or title): Coroner
23b. ADDRESS: Bannock Co. Idaho
23c. DATE SIGNED: 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: NOV 30 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature]
LICENSE NO.: E418
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4817
Local Reg. No. 326
Reg. Dist. No. 510

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 DEC 5 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (If not in place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): HANNAH
b. (Middle): E. 018
c. (Last): FREDRICKSON

4. DATE OF DEATH (Month) (Day) (Year): Nov. 25, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Mar. 31, 1881
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Oslo, Norway
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hans Hansen — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Julie Svendsen — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 334X Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility — Approx
DUE TO (c) Cerebro atherosclerosis — 7 Day

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from 11-19, 1967, to 11-25, 1967, that I last saw the deceased alive on 11-25, 1967, and that death occurred at 2:25 p m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Michael Alocava MD 774
23b. ADDRESS: Box 852 Kasiska Bldg
23c. DATE SIGNED: 12/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: DEC 4 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 1 1995

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECE

Certificate of Death

STATE OF IDAHO

State File No. 4818
Local Reg. No. 327
Reg. Dist. No. 510

BIRTH NO.

DEC 5 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 241 N. Garfield 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 241 N. Garfield

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	BYRON	B.	DOWNARD	Nov. 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Married 3	May 6, 1897	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Funeral Director 3d	Funeral Service	Marion, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew J. Downard	Ohio	Clara McDougle	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes Worls War I 3	519-40-4186	Mina M. Downard	Pocatello, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis with Cardiac Arrest. — INTERVAL BETWEEN ONSET AND DEATH: 15 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1952, 19__, *to* 11-26, 1967, *that I last saw the deceased alive on* 11-24, 1967, *and that death occurred at* 7:21 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David C. Miller, M.D.	Pocatello Idaho	11-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-29-67	Mountainview Cem.	Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 4 1967	Gloria Dopita	John P. Thomson	E-292

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Downard Funeral Home

DEC 1 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 4 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 31 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 9 1975

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

MAY 4 1977

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4819
Local Reg. No. 330
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 030 Bannock DEC 8 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lava Hot Springs
c. LENGTH OF STAY IN (Hospital or Institution) (Place) 6-00
d. FULL NAME OF HOSPITAL OR INSTITUTION 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grace 150
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last): Mathias Wilson Lowe

4. DATE OF DEATH (Month) (Day) (Year): November 30, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Jan. 11, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer-retired 04
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Franklin, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Thomas G. Lowe — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Maria Wilson — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Edward Maughan — ADDRESS: Bancroft, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 3318 Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 2 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 19 49, *to* Nov, 19 67, *that I last saw the deceased alive on* 27 Nov, 19 67, *and that death occurred at* 5:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. E. Keeran — 2260 (Degree or title) MD
23b. ADDRESS: Grace, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/4/67
24c. NAME OF CEMETERY OR CREMATORY: Grace Cemetery
24d. LOCATION (City, town, or county) (State): Grace, Idaho

DATE REC'D BY LOCAL REG. DEC 6 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Theodore S. Allen
LICENSE NO. E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 2 1980

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4820

Local Reg. No.

Reg. Dist. No. 552

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Bear Lake (040) — NOV 29 1967 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier — c. LENGTH OF STAY IN THIS PLACE: 0.00 — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Bear Lake (040) — CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier, Idaho — d. STREET ADDRESS (If rural, give location): 239 No. 10th

3. NAME OF DECEASED (Type or Print): (First) Lawrence (Middle) Thomas (Last) Lauridsen

4. DATE OF DEATH: (Month) Nov. (Day) 12. (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 5. 1887

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Stockman

10b. KIND OF BUSINESS OR INDUSTRY: 04

11. BIRTHPLACE (State or foreign country): Ovid, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Lauridsen — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Annie Jensen — BIRTHPLACE: Bloomington, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-34-0285A

17. INFORMANT'S OWN SIGNATURE: O. W. Lauridsen — ADDRESS: Montpelier Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 15m

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Cardiac failure — 1 yr

DUE TO (c) Emphysema — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Arteriosclerotic Heart Disease

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19____, *to* ____, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] MD (Degree or title) 458

23b. ADDRESS: Montpelier Idaho

23c. DATE SIGNED: 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 15, 1967

24c. NAME OF CEMETERY OR CREMATORY: Montpelier Cemetery

24d. LOCATION (City, town, or county) (State): Montpelier Idaho

DATE REC'D BY LOCAL REG.: 11-24-67

REGISTRAR'S SIGNATURE: Mrs. Ruby Gotcwsky

25. EMBALMER: Nile Matthews — LICENSE NO.: E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-630 21

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4821
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier, Idaho
c. LENGTH OF STAY (in this place) 3-02 2 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE Idaho
b. COUNTY Bear Lake 040
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. STREET ADDRESS (If rural, give location) 357 No. 4th St.

3. NAME OF DECEASED (Type or Print) a. (First) Jonathan b. (Middle) Pugmire 024 c. (Last) Keetch

4. DATE OF DEATH (Month) (Day) (Year) Nov. 14, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 10, 1888
9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer & Stockman
10b. KIND OF BUSINESS OR INDUSTRY 04
11. BIRTHPLACE (State or foreign country) St. Charles, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles G. Keetch BIRTHPLACE Green River, Wt
14. MOTHER'S MAIDEN NAME Helen N. Pugmire BIRTHPLACE St. Charles, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-18-2717A
17. INFORMANT'S OWN SIGNATURE Mrs Elaine Keetch ADDRESS Montpelier Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombosis Femoral Arteries — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes Mellitus — 5 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis — 5 years

19a. DATE OF OPERATION 11-14-67
19b. MAJOR FINDINGS OF OPERATION Fell of Rich Med Physical Exam
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-45 P.M., 1960, *to* 11-14, 1967, *that I last saw the deceased alive on* 11-14, 1967, *and that death occurred at* 7:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Fell of Rich (Degree or title) 439 Med 1
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY Wardboro Cemetery
24d. LOCATION (City, town, or county) Wardboro (State) Idaho

DATE REC'D BY LOCAL REG. 11-20-67
REGISTRAR'S SIGNATURE Mrs Ruby Gatcinsky
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4822
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 29 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 040 Bear Lake
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
c. LENGTH OF STAY (In hospital) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Dingle, Idaho 040
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Sue
b. (Middle) Myrtle 024
c. (Last) Taylor

4. DATE OF DEATH (Month) (Day) (Year) Nov. 17. 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Mar. 14. 1896
9. AGE (In years last birthday) 71
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Millshols, Ill.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Ratley
BIRTHPLACE Ill.
14. MOTHER'S MAIDEN NAME Laura Merritt
BIRTHPLACE Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give [illegible] dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Laura E. Unser
ADDRESS Fortbregg Calif

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1992

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, — INTERVAL BETWEEN ONSET AND DEATH 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary metastasis — 7 mo
DUE TO (c) Carcinoma Tsite

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Undetermined

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1967, *to* Nov, 1967 *that I last saw the deceased alive on* 17 Nov 1967, *and that death occurred at* 8:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE J W Schoppe MD (Degree or title) 458
23b. ADDRESS Montpelier Idaho
23c. DATE SIGNED 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal
24b. DATE Nov 21, 1967
24c. NAME OF CEMETERY OR CREMATORY Memorial Gardens
24d. LOCATION (City, town, or county) Spokane (State) Washington

DATE REC'D BY LOCAL REG. 11-24-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcensky
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4823
Local Reg. No.
Reg. Dist. No. 552

RECEIVED NOV 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Bear Lake (040) — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier Idaho — c. LENGTH OF STAY (in this place): 3-02 Idaho — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Bear Lake — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ovid Idaho (040) — d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) — a. (First): Charles — b. (Middle): Willard (024) — c. (Last): Carlson

4. DATE OF DEATH — (Month): Nov. — (Day): 19 — (Year): 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Dec. 21 1905

9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: 04

11. BIRTHPLACE (State or foreign country): Ovid Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Niels Carlson — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Julia M. Carlson — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-40-4393

17. INFORMANT'S OWN SIGNATURE: Gustave H. Carlson — ADDRESS: Ovid Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 m

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Coronary Sclerosis & Hypertension — 2 yrs

DUE TO (c): Hypertension — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Asthma — 1 yr

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov 16, 1967 *to* Nov 19, 1967 *that I last saw the deceased alive on* Nov 16, 1967 *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD 458 — **23b. ADDRESS**: Ovid Idaho — **23c. DATE SIGNED**: 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Nov 22 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Ovid Cemetery — **24d. LOCATION** (City, town, or county) (State): Ovid, Idaho.

DATE REC'D BY LOCAL REG.: 11-27-67 — REGISTRAR'S SIGNATURE: Mrs Ruby Gorczinski

25. EMBALMER: Nile Matthews — LICENSE NO.: E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form D-69021

DUTIES:

DEC 1 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 4 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4824
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED NOV 29 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier Idaho
c. LENGTH OF STAY (in this place) 3-04 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bear Lake Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Utah 45
b. COUNTY Rich
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Laketown Utah 555
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle) Lynn 024
c. (Last) Hymas

4. DATE OF DEATH (Month) (Day) (Year) Nov. 24 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Apr 27 1911

9. AGE (In years last birthday) 56
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Liberty Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Orson W. Hymas
BIRTHPLACE Hyde Park Ut.

14. MOTHER'S MAIDEN NAME Emma Shumway
BIRTHPLACE Paris Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes World War II

16. SOCIAL SECURITY NO. 476

17. INFORMANT'S OWN SIGNATURE Mrs. James L. Hymas
ADDRESS Laketown Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rheumatic Heart Disease — 5 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 11-24-67

19b. MAJOR FINDINGS OF OPERATION Autopsy

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, *to* 11-24, 1967, *that I last saw the deceased alive on* 11-24-67, 19—, *and that death occurred at* 1115 m., *from the causes and on the date stated above.*

23a. SIGNATURE Reed Rich (Degree or title) 439 MD

23b. ADDRESS Montpelier Ida

23c. DATE SIGNED 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 27, 1967

24c. NAME OF CEMETERY OR CREMATORY Bennington Cemetery

24d. LOCATION (City, town, or county) Bennington (State) Idaho

DATE REC'D BY LOCAL REG. 11-28-67

REGISTRAR'S SIGNATURE Mrs Ruby Gottinsky

25. EMBALMER Lile Matthews
LICENSE NO. E359
FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 13 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4825
Local Reg. No.
Reg. Dist. No. 552

Certificate of Death

RECEIVED
DEC 14 1967
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier, Idaho
c. LENGTH OF TOWNSHIP 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho 13
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bern Idaho 040
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Nellie b. (Middle) Parker c. (Last) Schmid

4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 8, 1896
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Lanark, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Parker — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Alice Gambling — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-40-8324
17. INFORMANT'S OWN SIGNATURE Irvins Schmid — ADDRESS Bern Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myo Cardial Infarction

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cardial Artery Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____ 19__ to _____ 19__, that I last saw the deceased alive on* 26 Nov, 1967, *and that death occurred at* 12 Noon *m., from the causes and on the date stated above.*

23a. SIGNATURE 458 [signature] (Degree or title)
23b. ADDRESS Med Arts
23c. DATE SIGNED 12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 30 1967
24c. NAME OF CEMETERY OR CREMATORY Bern Cemetery
24d. LOCATION (City, town, or county) Bern (State) Idaho

DATE REC'D BY LOCAL REG. 12-11-67
REGISTRAR'S SIGNATURE Mrs Ruby Gortcinski
25. EMBALMER Nile Matthews
LICENSE NO. E359

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: Matthews Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 10 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4826
Local Reg. No. 46
Reg. Dist. No. 130

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
NOV 29 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Benewah 050 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries - Rural
c. LENGTH OF STAY (in this place): few min
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 mi. north Highway 95A

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rathdrum 280
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print)
a. (First): Judy
b. (Middle): Marie 000
c. (Last): Kessinger

4. DATE OF DEATH (Month) (Day) (Year): November 13 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: August 13, 1946
9. AGE (In years last birthday): 21 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: North Idaho JC
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William W. Kessinger — BIRTHPLACE: Wyoming
14. MOTHER'S MAIDEN NAME: Gladys Mildred Davis — BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None 0
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: William W. Kessinger, Rt. 1 — ADDRESS: Rathdrum

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Skull fracture & concussion — INTERVAL BETWEEN ONSET AND DEATH: 10 m

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Fractured rt femur
Fractured ribs ant. bilat — 10 m

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Wilde road near 13 St. Maries
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 050 (STATE): Benewah Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11-13-67 9:20 p.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Auto accident

22. *I hereby certify that I attended the deceased from* OOH, 19__, *to* 11-13, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. D. Thurston 533 MD
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 11-13-67
24c. NAME OF CEMETERY OR CREMATORY: Hazen & Jaeger Crem.
24d. LOCATION (City, town, or county) (State): Spokane Washington

DATE REC'D BY LOCAL REG.: 11-22-67
REGISTRAR'S SIGNATURE: Wanda Dimiso
25. EMBALMER: Gerald E Browning
LICENSE NO.: E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 20 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4827
Local Reg. No. 41
Reg. Dist. No. 130

RECEIVED NOV 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5 Mls. No. of St. Maries

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene 281
d. STREET ADDRESS (If rural, give location) 918 Bancraft

3. NAME OF DECEASED (Type or Print) a. (First) Bonnie b. (Middle) Mae c. (Last) Swan

4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH 8-7-1949

9. AGE (In years last birthday) 18 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Clardston, Washington

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Albert M. Swan
BIRTHPLACE Mich.

14. MOTHER'S MAIDEN NAME Frances Daniels
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 539-42-3799

17. INFORMANT'S OWN SIGNATURE Marie Swan Webb, Coeur d' Alene, Id
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 8354 Skull fracture & Cerebral Hem — INTERVAL BETWEEN ONSET AND DEATH 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fractured wrist

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Driveway

21c. (CITY, TOWN, OR TOWNSHIP) near St. Maries (COUNTY) Benewah (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11 13 67 9:20 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Auto accident

22. I hereby certify that I attended the deceased from Dec 7, 19, to 11-13, 1967, that I last saw the deceased alive on 11-13, 1967, and that death occurred at 9 20/60 m., from the causes and on the date stated above.

23a. SIGNATURE W. D. Thomas (Degree or title) 533 MD

23b. ADDRESS St. Maries Idaho

23c. DATE SIGNED 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-18-1967

24c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. 11-22-67

REGISTRAR'S SIGNATURE Wanda Dimico

25. EMBALMER Fred H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4828
Local Reg. No. 48
Reg. Dist. No. 130

RECEIVED NOV 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050 1-17
b. CITY OR TOWN (If outside corporate limits or not in incorporated township): St. Maries
LENGTH OF STAY (in this place): 17 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home - 141 13th Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries 050
d. STREET ADDRESS (If rural, give location): 141 13th Street

3. NAME OF DECEASED (Type or Print): a. (First) Doris b. (Middle) Rosalie c. (Last) Richardson

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 17, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 14, 1922

9. AGE (In years last birthday): 45
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Wisconsin

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Emmett Mulhern
BIRTHPLACE: Wisconsin

14. MOTHER'S MAIDEN NAME: Jessie Hunter
BIRTHPLACE: Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None 0

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE: Ralph Richardson
ADDRESS: St. Maries

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 m

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis — Unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 19__, *to* 11-12, 1967, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 7:15 m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. D. Thurston 533 (Degree or title) MD
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery
24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: 11-22-67
REGISTRAR'S SIGNATURE: Harold Minnick
25. EMBALMER: Gerald Browning
LICENSE NO.: E-411

FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 6 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4829
Local Reg. No. 49
Reg. Dist. No. 130

BIRTH NO.

RECEIVED NOV 29 1967 Bureau of Vital Statistics

1-04

1. PLACE OF DEATH
a. COUNTY 050 Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries - Rural
c. LENGTH OF STAY (in this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home - Route 2 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries 050
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Fred	Charles	Sternberg	November 19 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	Nov. 21, 1888	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheet Metal Work 05	U. S. Navy	Illinois	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None 0	391-01-1172	Donald A. Sternberg	Rt 2 St Maries

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4201 Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 7:58 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. A. Rapp 428 M.D.	St. Maries Idaho	11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 22, 1967	Woodlawn Cemetery	St. Maries Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-22-67	Wanda Simms	David O. Hansen	E-510

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Browning Funeral Home

NOV 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

DISINTERMENT PERMIT

IDAHO STATE BOARD OF HEALTH

BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Fred Charles Stemberg

now lying buried in Woodlawn Cemetery, in the City or Town of St. Maries

County of Benewah State of Idaho, who died on the 19 day of November, 1967, Aged 78 years ____ months

____ days, the cause of death being Coronary thrombosis and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by

B. A. Rapp, M.D. attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Railway private or railway conveyance

to Westminster Memorial Park Cemetery in the City or Town of Westminster County of Orange

State of California to take effect upon the approval by the local board of health of the City, Town, or County of

Benewah it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the State Board of Health governing the Transportation of corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the State Board of Health at Boise, Idaho,

this 21st day of March, A.D. 19 68.

Permit issued to:
Browning Funeral Home
130 Eighth Street
St. Maries, Idaho 83861

W. W. Benson
By Director, Division of Vital Statistics
Joyce B Foltz

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City,

Town or County of ____ State of Idaho, this ____ day of ____, 19__.

Health Officer

FORM BH 56-019

TITLE 39, CHAPTER 2, VOL. 7 OF THE IDAHO CODE

"Sec. 39-211. No body shall be disinterred within the State of Idaho except upon a permit granted by the State Board of Health. The forms of disinterment permits shall be prepared by the State Board of Health. Disinterment and removal must be done under the personal supervision of a licensed embalmer, and must be done at an hour when there is the least possible exposure. Only such persons as are actually necessary shall be present. The coffin shall not be opened either at place of disinterment or place of destination, except special permit be issued by the State Board of Health. And in case of disinterment of bodies dead by reason of contagious and infectious diseases, as shown by the certificate of death given by the attending physician, the sexton and all other persons engaged in such removal or being present shall immediately thereafter change their clothing and properly disinfect their hands, head and face, provided, that such disinterment may also be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every permit: provided, also, that in case of any contagious and infectious disease where remains are to be shipped to points in other states, permission must first be obtained from the Secretary of State Board of Health of such State. The State Board of Health may also issue a special disinterment permit for legal purposes. This permit for legal purposes shall be granted only upon application of a prosecuting attorney or the Attorney General of this State, stating therein such facts which make it evident to the State Board of Health that the ends of justice require that disinterment be permitted. Such special disinterment for legal purposes shall be governed by rules and regulations promulgated by the State Board of Health and a synopsis of the same shall be printed on the back of every such special disinterment permit for legal purposes."

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4830
Local Reg. No. 50
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: BENEWAH 050 — DEC 7 1967 — 505
b. CITY OR TOWN: E mida-Rural FEW MIN
c. BUREAU OF VITAL STATISTICS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 MI E. Emida - Woods

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emida 050
d. STREET ADDRESS (If rural, give location): Box 2

3. NAME OF DECEASED (Type or Print)
a. (First): BENITO
b. (Middle): 000
c. (Last): GOICOECHEA

4. DATE OF DEATH: (Month) NOV. (Day) 26 (Year) 1967

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 19 1915

9. AGE (In years last birthday): 52
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Forest Service 08

10b. KIND OF BUSINESS OR INDUSTRY: St. Joe Nat. Forest

11. BIRTHPLACE (State or foreign country): NEVADA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Pedro Goicoechea
BIRTHPLACE: Spain

14. MOTHER'S MAIDEN NAME: Guadalupe Mendive
BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes WW 2 4

16. SOCIAL SECURITY NO.: 530-01-5982

17. INFORMANT'S OWN SIGNATURE: Joyce Goicoechea
ADDRESS: Box 2 Emida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* DOA, 19___, *to* 11-26, 1967, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: B. A. Rapp 428 (Degree or title): M.D.
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 12-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-30-1967
24c. NAME OF CEMETERY OR CREMATORY: Woodlawn
24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: Wanda Dimies
25. EMBALMER: Gerald Browning
LICENSE NO.: E-411
FIRM NAME: Browning Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 4 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4831
Local Reg. No. 52
Reg. Dist. No. 130

RECEIVED DEC 12 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Plummer
c. LENGTH OF STAY (in this place): few min
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pacific Crown Timber Prod.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Plummer 050
d. STREET ADDRESS (If rural, give location): At Residence

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Michael 000
c. (Last): Emerson

4. DATE OF DEATH (Month) (Day) (Year): November 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: March 16, 1958
9. AGE (In years last birthday): 9 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 03
10b. KIND OF BUSINESS OR INDUSTRY: Child
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Emerson — BIRTHPLACE: Lincoln, Wash.
14. MOTHER'S MAIDEN NAME: Arlie Crask — BIRTHPLACE: Rearden, Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None 0
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: George W. Emerson — ADDRESS: Plummer, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9363

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Crown Pacific Timber Mill 03
21c. (CITY, TOWN, OR TOWNSHIP): Plummer 13 (COUNTY): Benewah 050 (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 28 Nov 67 m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Caught in chain

22. *I hereby certify that I attended the deceased from* 0 2, 19__, *to* 0, 19__, *that I last saw the deceased alive on* 0, 19__, *and that death occurred at* P *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. Sullivan, M.D. 511 (Degree or title)
23b. ADDRESS: St. Maries, Idaho
23c. DATE SIGNED: 7 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 12-2-1967
24c. NAME OF CEMETERY OR CREMATORY: Greenwood Park
24d. LOCATION (City, town, or county) (State): Hunters, Washington

DATE REC'D BY LOCAL REG.: 12-7-67
REGISTRAR'S SIGNATURE: Wanda Dimico
25. EMBALMER: Gerald E. Browning — LICENSE NO. E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

DEC 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4832
Local Reg. No. 51
Reg. Dist. No. 130

RECEIVED DEC 12 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (In this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Comm. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Benewah 050
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries - Rural
d. STREET ADDRESS (If rural, give location) Rt. 3

3. NAME OF DECEASED (Type or Print)
a. (First) CLAR
b. (Middle) - 025
c. (Last) GREY

4. DATE OF DEATH (Month) (Day) (Year) Nov. 30 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never Married

8. DATE OF BIRTH 1-4-1897

9. AGE (In years last birthday) 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woods work 17

10b. KIND OF BUSINESS OR INDUSTRY Logging

11. BIRTHPLACE (State or foreign country) Michigan

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None 0

16. SOCIAL SECURITY NO. 519-22-8806

17. INFORMANT'S OWN SIGNATURE Mrs D. A. Eber
ADDRESS St. Maries Idaho

4801

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD — 10 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic G. U. Infection — 2 yrs.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14, 1966, *to* 11-30, 1967, *that I last saw the deceased alive on* 11-30, 1967, *and that death occurred at* 2:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Bruce E Rahuck 427 (Degree or title) MD
23b. ADDRESS St Maries, Ida
23c. DATE SIGNED 12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-2-1967
24c. NAME OF CEMETERY OR CREMATORY Woodlawn
24d. LOCATION (City, town, or county) St. Maries (State) Idaho

DATE REC'D BY LOCAL REG. 12-6-67
REGISTRAR'S SIGNATURE Hanna Dimico
25. EMBALMER Gerald Browning
LICENSE NO. E-411

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Browning Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4833
Local Reg. No. 132
Reg. Dist. No. 600

BIRTH NO.

RECEIVED NOV 10 1967 2-10 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN Blackfoot
c. LENGTH OF STAY (in this place) 10 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Nursing Home 304

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley 060
d. STREET ADDRESS (If rural, give location) Lowder Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First) Alfiell
b. (Middle) Elveta
c. (Last) Birdsall

4. DATE OF DEATH (Month) (Day) (Year) Nov. 2, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Aug. 20, 1883

9. AGE (In years last birthday) 84
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Swan Creek, Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Anderson
BIRTHPLACE Sweden

14. MOTHER'S MAIDEN NAME Charlotte Cederburg
BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs. Helen Clark ADDRESS Ashton

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CVA. Cardio-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* 2 Nov, 1967, *that I last saw the deceased alive on* 2 Oct, 1967 *and that death occurred at* 5:15 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE R. E. Mills Jr 361 (Degree or title) M.D.

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED 11-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-4-67

24c. NAME OF CEMETERY OR CREMATORY Ashton Cemetery

24d. LOCATION (City, town, or county) Ashton (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 7, 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER Howard Packham

LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4834
Local Reg. No. 138
Reg. Dist. No. 601

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)
c. LENGTH OF STAY (in this place) 5-05 Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Wolverine canyon 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot 061
d. STREET ADDRESS (If rural, give location) 610 Ridge St.

3. NAME OF DECEASED (Type or Print) a. (First) CLAUDE b. (Middle) c. (Last) ADAMS

4. DATE OF DEATH (Month) (Day) (Year) November 4, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH May 2, 1909

9. AGE (In years last birthday) 58
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shop foreman 08

10b. KIND OF BUSINESS OR INDUSTRY City of Blackfoot

11. BIRTHPLACE (State or foreign country) Turner, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Adams
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Myrtle Chadwick
BIRTHPLACE Franklin, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-18-1267

17. INFORMANT'S OWN SIGNATURE Melba Adams ADDRESS Blackfoot, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4532

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ruptured aneurysm — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Aneurysm of carotid artery

DUE TO (c) Strenuous repair operation

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Wolverine Canyon 15 mile NE Blackfoot Bingham Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 4, 1967, *to* ~~Nov 4, 1967~~, *that I last saw the deceased alive on* ~~19xx~~, *and that death occurred at* 4:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Carl Stiles 583 (Degree or title) Coroner

23b. ADDRESS Blackfoot, Idaho

23c. DATE SIGNED Nov 6,67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov 8,67

24c. NAME OF CEMETERY OR CREMATORY Moreland cemetery

24d. LOCATION (City, town, or county) (State) Blackfoot Idaho

DATE REC'D BY LOCAL REG. Nov 14,1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER C. Dean Hill

LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4835
Local Reg. No. 739
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 061 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Rest-Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): R#2 Shelley, 060
d. STREET ADDRESS (If rural, give location): Route # 2

3. NAME OF DECEASED (Type or Print): a. (First) Hiram b. (Middle) R. c. (Last) Christensen

4. DATE OF DEATH: (Month) Nov (Day) 4 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: Whid e

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 1 April 1878

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hyrum, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Niels Christensen
BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Anna Maria Petersen
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 619-60-4693

17. INFORMANT'S OWN SIGNATURE: Leland E. Christensen
ADDRESS: R#2 Shelley

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4200 Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 1967, *to* Nov. 4, 1967, *that I last saw the deceased alive on* Oct. 27, 1967, *and that death occurred at* 10:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE: J. M. Withers MD (Degree or title) 569
23b. ADDRESS: Blackfoot Idaho
23c. DATE SIGNED: 11-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8 Nov 1967
24c. NAME OF CEMETERY OR CREMATORY: Goshen,
24d. LOCATION (City, town, or county) (State): R#2 Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG.: Nov. 17, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Floyd M. Walden
LICENSE NO.: E275
FIRM NAME: Walden Funeral Home Shelley Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4836
Local Reg. No. 137
Reg. Dist. No. 600

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 061 Blackfoot 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street or address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot 061
d. STREET ADDRESS (If rural, give location): 444 North Ash St.

3. NAME OF DECEASED (Type or Print)
a. (First): BERTHA
b. (Middle): ELIZABETH
c. (Last): BOWMAN

4. DATE OF DEATH (Month) (Day) (Year): November 4 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: October 13, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Elk Horn, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: William D. Moulton — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Mary L. Lee — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Gene Bowman — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

157X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma head of Pancreas — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Jaundice — 1 wk.
Renal shutdown — 4 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 30, 19__, *to* Nov 4, 19 67 *that I last saw the deceased alive on* Nov 4, 19 67, *and that death occurred at* 11:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. Dean Packer 403 M.D.
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Nov 6, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Nov 14, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: C. Dean Hill
LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 12 1993

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 4837
Local Reg. No. 140
Reg. Dist. No. 601

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural) 221
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Interstate Hiway 15- 5 niles N.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location): 248 North 6th East

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): KING 000
c. (Last): HILLMAN

4. DATE OF DEATH (Month) (Day) (Year): November 5, 1967

5. SEX: Male
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 26 Sept 1925
9. AGE (In years last birthday): 42 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Attorney 16
10b. KIND OF BUSINESS OR INDUSTRY: Self Employed
11. BIRTHPLACE (State or foreign country): Rexburg, Idaho RFD#1 (Plano)
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert K. Hillman — BIRTHPLACE: Plano, Idaho
14. MOTHER'S MAIDEN NAME: Sarah Hunter — BIRTHPLACE: Oakley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 519-22-0809
17. INFORMANT'S OWN SIGNATURE: + Alice S. Hillman — ADDRESS: St. Anthony, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Exposure — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Wet in water with 8° temperature
DUE TO (c): Car accident

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 1 accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 061 (STATE): Mother No. IS 15 13 Blackfoot Bingham Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sold not the deceased (18 hrs) *, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl Staley 583 Coroner 4
23b. ADDRESS: 321 E. Walker Blackfoot
23c. DATE SIGNED: 11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 8 Nov 67
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county) (State): Idaho Falls, Bonneville, Idaho

DATE REC'D BY LOCAL REG.: Nov. 14, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: M. S. Hansen — LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 29 1967

DEC 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4838
Local Reg. No. 141
Reg. Dist. No. 601

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 060
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Highway 91
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 255 West 18th

3. NAME OF DECEASED (Type or Print)
a. (First): GARY
b. (Middle): BRADLEY
c. (Last): RUMSEY

4. DATE OF DEATH (Month) (Day) (Year): Nov 5, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: 8 Dec. 1928
9. AGE (In years last birthday): 38 — If under 1 year: Months 10, Days 27 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 06 Operator
10b. KIND OF BUSINESS OR INDUSTRY: A. E. C.
11. BIRTHPLACE (State or foreign country): St. Anthony, Idaho. (Egin)
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: George B. Runsey — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Annabelle Strong — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: James J. Rumsey — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8234

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Exposure — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Being wet & in the water at 8° temp.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 1 accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): I.S. 15 13 4 miles N. Blackfoot Bingham 061 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Car accident

22. *I hereby certify that I attended the deceased from* Nov 1, 19__, *to* Nov 5, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl Stoley Coroner 583 4
23b. ADDRESS: 321 E Walker Blackfoot Ida
23c. DATE SIGNED: 11-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem & Burial 3
24b. DATE: Nov 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Wilford Cemetery
24d. LOCATION (City, town, or county) (State): St. Anthony, Rural Route

DATE REC'D BY LOCAL REG.: Nov 13, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Leo A Williams
LICENSE NO.: E-319

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 29 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4839
Local Reg. No. 142
Reg. Dist. No. 600

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 1mo29da
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Thornton 330
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)
a. (First): WINNIE
b. (Middle): A.
c. (Last): RAWLS

4. DATE OF DEATH (Month) (Day) (Year): November 5 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 17 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Texas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles E. Bollinger — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Lula Hawsley — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE Mary Payne ADDRESS: Med. Records-State Hospital South

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4918

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Bronchial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Upper Respiratory Tract Infection — 3 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 Aug., 1967, *to* 5 Nov., 1967, *that I last saw the deceased alive on* 5 Nov., 1967, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 594 (Degree or title)
23b. ADDRESS State Hospital South-Blackfoot, Idaho
23c. DATE SIGNED 7 Nov. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 9 1967
24c. NAME OF CEMETERY OR CREMATORY: Sutton Cemetery
24d. LOCATION (City, town, or county) (State): Madison County, Idaho

DATE REC'D BY LOCAL REG.: Nov. 15, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: James R. Flamm — LICENSE NO.: E 477

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4840
Local Reg. No. 133
Reg. Dist. No. 600

Certificate of Death

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LIMITS OF STAY (in this place): 2mo8day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ketchum 070
d. STREET ADDRESS (If rural, give location): Box 513

3. NAME OF DECEASED (Type or Print)
a. (First): MARJORIE
b. (Middle): V.
c. (Last): JENKINS

4. DATE OF DEATH (Month) (Day) (Year): November 6 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 13 April 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stenographer 10
10b. KIND OF BUSINESS OR INDUSTRY: U.P. Railroad
11. BIRTHPLACE (State or foreign country): Illinois (Decatur)
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Fred B. Reid — BIRTHPLACE: not given
14. MOTHER'S MAIDEN NAME: Blanche — BIRTHPLACE: not given

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mary Payne — ADDRESS: Med. Records-State Hospital South

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatic Insufficiency due to cirrhosis - advanced — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Alcoholism — yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 29 Aug., 19 67, *to* 6 Nov., 19 67, *that I last saw the deceased alive on* 6 Nov., 19 67, *and that death occurred at* 11:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Mary Louise Smith, MD 594 (Degree or title)
23b. ADDRESS: State Hospital South, Blackfoot
23c. DATE SIGNED: 8 Nov. '67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem. & Cremation
24b. DATE: 11/8/67
24c. NAME OF CEMETERY OR CREMATORY: Aultorest Memorial Corp.
24d. LOCATION (City, town, or county) (State): Ogden, Utah

DATE REC'D BY LOCAL REG.: Nov. 9, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Howard Packham
LICENSE NO.: E-338

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Howard Packham Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 10 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4841
Local Reg. No. 143
Reg. Dist. No. 600

BIRTH NO.

RECEIVED NOV 2 0 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 3-01 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot 061
d. STREET ADDRESS (If rural, give location) 489 East Bridge St.

3. NAME OF DECEASED (Type or Print)
a. (First) GRACE
b. (Middle) YANCEY 029
c. (Last) COVERT

4. DATE OF DEATH (Month) (Day) (Year) November 7 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH August 26, 1892
9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Hooper, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Richard Yancey
BIRTHPLACE
14. MOTHER'S MAIDEN NAME Telitha Smith
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-28-2875
17. INFORMANT'S OWN SIGNATURE Hugh Covert ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 19 66, *to* Nov 7, 19 67, *that I last saw the deceased alive on* Nov 7, 19 67, *and that death occurred at* 6:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 197 M.D.
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED Nov 10, 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Ucon Cemetery
24d. LOCATION (City, town, or county) Ucon (State) Idaho

DATE REC'D BY LOCAL REG. Nov 14, 1967
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER
LICENSE NO. E-466
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4842
Local Reg. No. 145
Reg. Dist. No. 600

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 19 yrs. 7 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 060
d. STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print)
a. (First) VINCENT
b. (Middle) De PAUL
c. (Last) HEWITT

4. DATE OF DEATH (Month) (Day) (Year) November 8 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH 28 Sept. 1909
9. AGE (In years last birthday) 58 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Hewitt — BIRTHPLACE Wisconsin
14. MOTHER'S MAIDEN NAME Sarah McGinnis — BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 836 07 1846
17. INFORMANT'S OWN SIGNATURE Mary Payne ADDRESS Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema resulting from acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 7 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (secondary to coronary thrombosis)
DUE TO (c) Congestive Heart failure

II. OTHER SIGNIFICANT CONDITIONS Gen. arteriosclerosis
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 Nov, 1967, *to* 8 Nov., 1967, *that I last saw the deceased alive on* 8 Nov., 1967, *and that death occurred at* 5:45p *m., from the causes and on the date stated above.*

23a. SIGNATURE C. Stillman M.D. 594 (Degree or title)
23b. ADDRESS State Hospital South-Blackfoot, Idaho
23c. DATE SIGNED 14 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Nov 10, 1967
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. Nov 14, 1967
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER C. Dean Hill
LICENSE NO. E 466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4843
Local Reg. No. 144
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

1-02

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (In this place) 2yr 11mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello 031
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) VILLA b. (Middle) S. c. (Last) LaPORTE

4. DATE OF DEATH (Month) (Day) (Year) November 8 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH 12 Sept. 1913
9. AGE (In years last birthday) 54 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Wyoming
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph H. Smith BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Sarah H. Light BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mary Coyne ADDRESS Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

355 X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Pyelonephritis associated with staghorn calculus — INTERVAL BETWEEN ONSET AND DEATH: Indef.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Severe emaciation or debility
DUE TO (c) Huntington's Chorea

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4 Dec. , 1964, *to* 8 Nov. , 19 67, *that I last saw the deceased alive on* 8 Nov. , 19 67 *and that death occurred at* 8:05a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 594 MD
23b. ADDRESS State Hospital South, Blackfoot, Idaho
23c. DATE SIGNED 14 Nov '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Malad Cemetery
24d. LOCATION (City, town, or county) (State) Malad, Oneida, Idaho

DATE REC'D BY LOCAL REG. 11-17-67
REGISTRAR'S SIGNATURE Dorothy L. Jones
25. EMBALMER T. B. Allen
LICENSE NO. E418
FIRM NAME:

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 20 1967

NOV 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4844
Local Reg. No. 146
Reg. Dist. No. 600

BIRTH NO.

RECEIVED NOV 8 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061 2-01
b. CITY OR TOWN Blackfoot
LENGTH OF STAY (in this place) 1mo14da
d. FULL NAME OF HOSPITAL OR INSTITUTION State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN Aberdeen 060
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) R.
c. (Last) CARTER

4. DATE OF DEATH (Month) (Day) (Year) November 11 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed2

8. DATE OF BIRTH January 1, 1883

9. AGE (In years last birthday) 84
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 60 4692

17. INFORMANT'S OWN SIGNATURE Med. Records-State Hospital South
ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 27 Sept., 1967, *to* 11 Nov., 19 67, *that I last saw the deceased alive on* 11 Nov, 19 67, *and that death occurred at* 3:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 594 (Degree or title)

23b. ADDRESS State Hospital South - Blackfoot, Idaho

23c. DATE SIGNED 14 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE Nov 17 1967

24c. NAME OF CEMETERY OR CREMATORY Memorial Cemetery

24d. LOCATION (City, town, or county) (State) Broken Arrow, Oklahoma

DATE REC'D BY LOCAL REG. Nov. 14, 1967

REGISTRAR'S SIGNATURE Dorothy J. Jones

25. EMBALMER C. Dean Hill

LICENSE NO. E466

FIRM NAME: Sandberg-Hill

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4845
Local Reg. No. 177
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): Pocatello Heights

3. NAME OF DECEASED (Type or Print): a. (First) CLYDE b. (Middle) A. c. (Last) DISHER

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 12, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Aug. 1, 1915

9. AGE (In years last birthday): 52
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Conductor 10

10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.

11. BIRTHPLACE (State or foreign country): Ogden, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Clyde Disher
BIRTHPLACE: Indiana

14. MOTHER'S MAIDEN NAME: Alice LaPash
BIRTHPLACE: Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: [signature]
ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

420.1

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Did not see alive, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ralph W. Coates 183 (Degree or title) MD

23b. ADDRESS: Blackfoot Idaho

23c. DATE SIGNED: Nov 16 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 15, 1967

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.: Nov. 17, 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: [signature]

LICENSE NO.: E418

FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 4 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 7 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4846
Local Reg. No. 148
Reg. Dist. No. 600

BIRTH NO.

RECEIVED NOV 24 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot 061
d. STREET ADDRESS (If rural, give location): 264 North Spruce

3. NAME OF DECEASED (Type or Print)
a. (First): MARINDA
b. (Middle): CHRISTENA 304
c. (Last): PETERSON

4. DATE OF DEATH (Month) (Day) (Year): November 14, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: February 22, 1868
9. AGE (In years last birthday): 99 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Goshen, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hans Jesperson — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME: Marinda Ipson — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-60-4695
17. INFORMANT'S OWN SIGNATURE: Goldie McCulloch — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH 0969
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Viral infection — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Generalized arteriosclerosis.
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 48, *to* November 14, 19 67, *that I last saw the deceased alive on* Nov 13, 19 67, *and that death occurred at* 11:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 404 MD 1
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Nov 17, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov 17, 67
24c. NAME OF CEMETERY OR CREMATORY: Groveland cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Nov. 20, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: C. Dean Hill
LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 9 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4847
Local Reg. No. 153
Reg. Dist. No. 600

BIRTH NO.

RECEIVED
DEC 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY IN (this place) 35yr4mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello, 031
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WARNER		GRANT	November 18 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Negro	Never Married	July 21 1873	94				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06		Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis Johnston	Missouri	Nellie Grant	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			Mary Payne	Med. Records-State Hospital South

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4208

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterioscierotic Heart Disease — Interval between onset and death: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) General Arteriosclerosis — Years

DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1 July, 1962, *to* 18 Nov., 19 67, *that I last saw the deceased alive on* 18 Nov., 19 67, *and that death occurred at* 6:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Stallings MD 594	State Hospital South - Blackfoot, Idaho	30 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	20 Nov 67	Mountain View	Pocatello	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 18 1967	Dorothy A. Jones	E. Dean Hill	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 1 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4848
Local Reg. No. 149
Reg. Dist. No. 601

BIRTH NO.

RECEIVED NOV 24 1967 Bureau of Vital Statistics

1-32

1. PLACE OF DEATH
a. COUNTY 060 Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Springfield
LENGTH OF STAY (in this place) 32 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 4½ miles South of Springfield

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Springfield Rural 060
d. STREET ADDRESS (If rural, give location) none 4½ mi.So. of Springfield

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Charles c. (Last) Reid

4. DATE OF DEATH (Month) (Day) (Year) Nov. 18, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH July 18, 1889
9. AGE (In years last birthday) 78 IF UNDER 1 YEAR Months Days IF UNDER A DAY Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stockman 04
10b. KIND OF BUSINESS OR INDUSTRY Cattle Ranch
11. BIRTHPLACE (State or foreign country) McCammon, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James E. Reid
BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME Belle Goodenough
BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW 1 1918-19 3
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Mildred Reid ADDRESS Springfield, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) Rt 2 Blackfoot (COUNTY) Bingham (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see him alive About *, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at* 8 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE Earl Staley 583 (Degree or title) Coroner
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED 11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-22-67
24c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery
24d. LOCATION (City, town, or county) (State) Springfield, Bingham, Idaho

DATE REC'D BY LOCAL REG. Nov 21, 1967
REGISTRAR'S SIGNATURE Dorothy J Jones
25. EMBALMER Howard Packham
LICENSE NO. E-338

FIRM NAME: Howard Packham Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 11 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4849
Local Reg. No. 150
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Bingham 060 — DEC 5 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): R#1 Shelley, Idaho — c. LENGTH OF STAY (At place of death): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley, Idaho 060
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Francis	Marion	Davis	Nov	22	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	9 July 1883	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Provo, Utah
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: James B. Davis — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Elizabeth Hodson — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-12-0142
17. INFORMANT'S OWN SIGNATURE: Harold S. Davis — ADDRESS: Richland, Wash.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): LACERATION AND PERFORATION OF HEART & HEMOTHORAX — INTERVAL BETWEEN ONSET AND DEATH: INSTANT

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): PULMONARY OUTFLOW CHANNEL OF LEFT VENTRICLE BY BONE ENDS OF FRACTURED MIDSTERNUM

DUE TO (c): STEERING WHEEL INJURY SEVERE TO CHEST IN SINGLE VEHICLE ACCIDENT (LEFT ROAD AND ENTERED IRRIGATION CANAL

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: ARTERIOSCLEROSIS, GENERALIZED MODERATE

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
ACCIDENT	04	NEAR SHELLEY 13	BINGHAM 060	IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____ 19____ *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hazel L. McGaffey M.D. 342 — HAZEL L. MC GAFFEY, M.D. PATHOLOGIST
23b. ADDRESS: 2525 South Boulevard Idaho Falls
23c. DATE SIGNED: 11/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	LICENSE NO.
Burial	Nov 25 1967	Hill Crest	Shelley, Bingham Idaho	

DATE REC'D BY LOCAL REG.: Dec 1, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: L. M. Nalder — LICENSE NO.: E275
FIRM NAME: Nalder Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 5 1968

JUN 27 2016

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4850
Local Reg. No. 737
Reg. Dist. No. 601

Certificate of Death

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 060
a. COUNTY Bingham
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) R#1 Shelley,
LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 060 Shelley,
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Oscar b. (Middle) L. c. (Last) Nelson

4. DATE OF DEATH (Month) (Day) (Year) Nov 23 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Jan 16 1896
9. AGE (In years last birthday) 71 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Shelley, Idaho
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Peter L. Nelson BIRTHPLACE
14. MOTHER'S MAIDEN NAME Amelia BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1 3
16. SOCIAL SECURITY NO. 519-09-2556
17. INFORMANT'S OWN SIGNATURE ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broken neck (cervical spine) — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Car accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 04
21c. (CITY, TOWN, OR TOWNSHIP) West 13 Shelley (COUNTY) Bingham 060 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11 23-65 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* I did not see victim alive *19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Carl Staley 583 (Degree or title) Coroner 4
23b. ADDRESS 321 E Walker Blackfoot
23c. DATE SIGNED 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-27-67
24c. NAME OF CEMETERY OR CREMATORY Hill Crest
24d. LOCATION (City, town, or county) (State) Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG. Nov. 29, 1967
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER Lloyd M. Nalder Lloyd M. Nalder
LICENSE NO. E-275

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Nalder's Funeral HOme

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 10 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4851
Local Reg. No. 157
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061 — 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 468 West Center St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot 061
d. STREET ADDRESS (If rural, give location): 468 West Center St.

3. NAME OF DECEASED (Type or Print): a. (First) HILDA b. (Middle) LUELLA c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year): November 24, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: January 26, 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Annis, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Elisha M. Wilbur — BIRTHPLACE: Eden, Utah
14. MOTHER'S MAIDEN NAME: Lydia E. Carr — BIRTHPLACE: Promontory Point Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: William W Smith — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: Instaneous

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac Decompensation — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1952, 19__, *to* Nov 24, 19 67, *that I last saw the deceased alive on* Nov 15, 1967, *and that death occurred at* 7:00a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ralph Slade 183 (Degree or title) M.D.
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Nov 27,67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov 27,1967
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Dec. 4-1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: L. Dean Hill
LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form OH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4852
Local Reg. No. 154
Reg. Dist. No. 601

RECEIVED DEC 18 1967

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural)
c. LENGTH OF STAY (in this place) 1-00 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route 3 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot (Rural) 061
d. STREET ADDRESS (If rural, give location) Route 3

3. NAME OF DECEASED (Type or Print) a. (First) MALIN b. (Middle) c. (Last) ROBINSON

4. DATE OF DEATH (Month) (Day) (Year) November 25, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH July 5, 1898
9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Franklin, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Samuel J. Robinson BIRTHPLACE AmericanFork, Utah
14. MOTHER'S MAIDEN NAME Celia E. Brown BIRTHPLACE Willard, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-42-9339
17. INFORMANT'S OWN SIGNATURE LolaDawn Hernandez ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~Nov~~ November 25 67, [redacted], *and that death occurred at* 4:00a. m., *from the causes and on the date stated above.*

23a. SIGNATURE Carl Sharp 583 (Degree or title) Coroner
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED Nov 27, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE November 28, 67
24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery
24d. LOCATION (City, town, or county) Blackfoot (State) Idaho

DATE REC'D BY LOCAL REG. 12-4-67
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER K. Dean Hill
LICENSE NO. E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the District WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4853
Local Reg. No. 153
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 060 DEC 1 8 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural (Blackfoot)
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route 3 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural (Blackfoot) 060
d. STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print): a. (First) FRANK b. (Middle) c. (Last) WHITTEN

4. DATE OF DEATH (Month) (Day) (Year): November 26, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: January 26, 1884

9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Chico, California

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alpheus Whitten — BIRTHPLACE: Kanaan, Maine

14. MOTHER'S MAIDEN NAME: Susan E. Fox Bennett — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Francis A. Whitten — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

593X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Hypertension — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Kidney Failure
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased* [redacted] Nov 26, 19 67, [redacted] *and that death occurred at* [redacted] A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Carl Slotz 583 — (Degree or title): Coroner 4

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: Nov 27, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Nov 30, 67

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: 12-4-67

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: Dean Hill — LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 0 1991

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death, or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4854
Local Reg. No. 159
Reg. Dist. No. 600

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 18 1967 Bureau of Vital Stat.

1. PLACE OF DEATH
a. COUNTY Bingham 061 1-13
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 13 yrllmo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls 101
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) BELLE b. (Middle) c. (Last) Mc DONALD

4. DATE OF DEATH (Month) (Day) (Year) November 30 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH 1 Feb. 1907
9. AGE (In years last birthday) 60 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Brigham E. Hamilton BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Nancy Gentry BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Mary Payne ADDRESS Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1551

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of gallbladder and metastasis of liver and lymph nodes — INTERVAL BETWEEN ONSET AND DEATH: Indefinite

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Anemia, electrolytes imbalance toxicity of bile in blood & tissues — "
DUE TO (c) Hepatic insufficiency — "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 July, 1962, *to* 30 Nov., 1967, *that I last saw the deceased alive on* 30 Nov., 1967, *and that death occurred at* 8:45p *m., from the causes and on the date stated above.*

23a. SIGNATURE C. Stillinger MD 594 (Degree or title) 1
23b. ADDRESS State Hospital South - Blackfoot, Idaho
23c. DATE SIGNED 4 Dec. 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11-1-67
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) Price, (State) Utah

DATE REC'D BY LOCAL REG. 12-4-67
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER Howard Packham LICENSE NO. E-338

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Howard Packham Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4855
Local Reg. No. 156
Reg. Dist. No. 600

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot
c. LENGTH OF STAY (in this place) 5 days 3-05
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bingham Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Blackfoot 061
d. STREET ADDRESS (If rural, give location) 1665 Dennis St.

3. NAME OF DECEASED (Type or Print)
a. (First) PAUL
b. (Middle) E. 029
c. (Last) CRANE

4. DATE OF DEATH (Month) (Day) (Year) November 30, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH April 22, 1921
9. AGE (In years last birthday) 46 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) District Judge 16
10b. KIND OF BUSINESS OR INDUSTRY District Judge
11. BIRTHPLACE (State or foreign country) Dennison, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John H. Crane — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Elizabeth E. Ash — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) World War II 4
16. SOCIAL SECURITY NO. 339-16-6561
17. INFORMANT'S OWN SIGNATURE Ellen M. Crane — ADDRESS Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 12 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

151X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to* Nov 30, 1967, *that I last saw the deceased alive on* Nov 29, 1967, *and that death occurred at* 12:05 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 197 (Degree or title) M.D. 1
23b. ADDRESS Blackfoot, Idaho
23c. DATE SIGNED Nov 30, 67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 1
24b. DATE Dec 2, 1967
24c. NAME OF CEMETERY OR CREMATORY Challis cemetery
24d. LOCATION (City, town, or county) Challis (State) Idaho

DATE REC'D BY LOCAL REG. 12-4-67
REGISTRAR'S SIGNATURE Dorothy J. Jones
25. EMBALMER John C Sandberg — LICENSE NO. E-280
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 16 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 29 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 6 1968

DEC 17 1970

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4856
Local Reg. No. 158
Reg. Dist. No. 601

RECEIVED
DEC 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 060 1-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pingree
c. LENGTH OF STAY (in this place): 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pingree 060
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle): EARL
c. (Last): TAGGART

4. DATE OF DEATH (Month) (Day) (Year): November 30, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: October 15, 1917
9. AGE (In years last birthday): 50 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocer 25
10b. KIND OF BUSINESS OR INDUSTRY: Grocery
11. BIRTHPLACE (State or foreign country): Aberdeen, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George S. Taggart — BIRTHPLACE: Morgan, Utah
14. MOTHER'S MAIDEN NAME: Charlotte Earl — BIRTHPLACE: South Weber, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Marsha McBride — ADDRESS: Pingree, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH: Imm.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased* ~~from~~ November 30, 1967, ~~[illegible]~~, *and that death occurred at* 2:00p. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 1971
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Dec 2, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Riverside-Thomas cemetery
24d. LOCATION (City, town, or county) (State): Bingham county, Idaho

DATE REC'D BY LOCAL REG.: Dec 4, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: C. Dean Hill — LICENSE NO. E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 19 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 1 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4857
Local Reg. No. 52
Reg. Dist. No. 410

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place): 5 days 3-05
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey 070
d. STREET ADDRESS (If rural, give location): 411 North Main

3. NAME OF DECEASED (Type or Print)
a. (First): Hassell
b. (Middle):
c. (Last): Blankenship

4. DATE OF DEATH (Month) (Day) (Year): Nov. 16, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: June 8, 1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Wool grower 04
10b. KIND OF BUSINESS OR INDUSTRY: retired
11. BIRTHPLACE (State or foreign country): Flag Pond, Tenn
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jonas O. Blankenship, BIRTHPLACE: Tenn.
14. MOTHER'S MAIDEN NAME: Ann Eliza Chandley, BIRTHPLACE: North Carlonia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-34-3550
17. INFORMANT'S OWN SIGNATURE: Harriet O. Blankenship, ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1539 Leommorhage from Bowl — INTERVAL BETWEEN ONSET AND DEATH: 12 h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adenocorcinoma — ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Nov 11 1967
19b. MAJOR FINDINGS OF OPERATION: Pleuritis
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 11, 1967, *to* Nov 16, 1967, *that I last saw the deceased alive on* Nov 16, 1967, *and that death occurred at* 64 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 455 (Degree or title) MD
23b. ADDRESS: Sun Valley, Idaho
23c. DATE SIGNED: Nov 17 67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 11/20/67
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov-18-1967
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird [signature]
LICENSE NO.: E- 373

Federal Security Agency
United States Public Health Service

Form DH-63021 per [signature]

FIRM NAME: Bird Funeral Home, Hailey, I

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 18 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4858
Local Reg. No. 53
Reg. Dist. No. 4-10

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sun Valley
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ketchum 070
d. STREET ADDRESS (If rural, give location) Apt. 25, Bald Mt.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	STELLA	WOOTTON	CARLILE	Nov. 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	8-12-06	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife 01	Home	Midway Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Richard Wootton	Utah	Orpha Fraughton	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	528 26 0574	William W. Carlile	Ketchum, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 3327 Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-16, 1967, *to* 11-17, 1967, *that I last saw the deceased alive on* 11-17, 1967 *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Marshall Henderson M.D. 752 (Degree or title)	Sun Valley, Idaho	11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 21, 67	Ketchum Cemetery	Ketchum Idaho

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov-24-67	Robert H. Wright	Keith Bird Keith Bird	E-373

FIRM NAME Bird Funeral Home, Hailey, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev 6-BW

DUTIES:

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Boy

Certificate of Death

State File No. 4859
Local Reg. No. 56
Reg. Dist. No. 410

BIRTH NO.

RECEIVED STATE OF IDAHO

NOV 30 1967 3-01

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Carey, Rural
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Carey Lake, 1Mi. E.ofCarey

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY Los Angeles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pasadena 555
d. STREET ADDRESS (If rural, give location) 621 Foxwood Road

3. NAME OF DECEASED (Type or Print)
a. (First) Mark
b. (Middle) 000
c. (Last) Froehlich

4. DATE OF DEATH (Month) (Day) (Year) Nov. 24, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married 1
8. DATE OF BIRTH Oct. 16, 1957
9. AGE (In years last birthday) 10 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 03
10b. KIND OF BUSINESS OR INDUSTRY Student
11. BIRTHPLACE (State or foreign country) Glendale California
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jack E. Froehlich — BIRTHPLACE California
14. MOTHER'S MAIDEN NAME Marian Crofts — BIRTHPLACE California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE By Phone from Mrs Froehlich — ADDRESS Pasadena

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

850X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Carey Lake 18
21c. (CITY, TOWN, OR TOWNSHIP) Carey 13 — (COUNTY) Blaine 070 — (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11 24 '67 6 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Boat overturned while hunting

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 583 (Degree or title) Dr. Ed Earle Coroner 4
23b. ADDRESS Sun Valley Idaho
23c. DATE SIGNED 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Nov. 27, 67
24c. NAME OF CEMETERY OR CREMATORY Forest Lawn Cemetery
24d. LOCATION (City, town, or county) Glendale California (State)

DATE REC'D BY LOCAL REG. Nov. 29 '67
REGISTRAR'S SIGNATURE Robert H. Wright
25. EMBALMER Keith Bird — Keith Bird — LICENSE NO. E-373

Federal Security Agency
United States Public Health Service

Form DH-63021 per EBW

FIRM NAME: Bird Funeral Home, Hailey

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Father

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4860
Local Reg. No. 55
Reg. Dist. No. 410

BIRTH NO.

070 NOV 30 1967 3-01

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Carey, Rural
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carey Lake, 1Mi.E.ofCarey

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California 05
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pasadena 555
d. STREET ADDRESS (If rural, give location): 621 Foxwood Road

3. NAME OF DECEASED (Type or Print)
a. (First): JACK
b. (Middle): EDWARD 000
c. (Last): FROEHLICH

4. DATE OF DEATH (Month) (Day) (Year): Nov. 24, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: May 7, 1921
9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nat. Eng. Science Co. 30 21
10b. KIND OF BUSINESS OR INDUSTRY: Eng. Reaearch
11. BIRTHPLACE (State or foreign country): Stockton California
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Adolph H. Froehlich — BIRTHPLACE: Mo.
14. MOTHER'S MAIDEN NAME: Maude L. Gilespil — BIRTHPLACE: Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: by Phone Mrs Marian Froehlich — ADDRESS: Pasadena

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

850X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Carey Lake 18
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 070 (STATE): Carey 13 Blaine Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 4 24 67 6 P m. 2
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Boat overturned while hunting

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): A. Scott Earle 583 Coroner 4
23b. ADDRESS: Sun Valley Idaho
23c. DATE SIGNED: 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 27, 67
24c. NAME OF CEMETERY OR CREMATORY: Forest Lawn Cemetery
24d. LOCATION (City, town, or county) (State): Glendale California

DATE REC'D BY LOCAL REG.: Nov. 29/67
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird — Keith Bird
LICENSE NO.: E-373

Federal Security Agency
United States Public Health Service

Form DH-63021 for CBW

FIRM NAME: Bird Funeral Home, Hailey

DEC 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

PECEIVED STATE OF IDAHO

State File No. 4861
Local Reg. No. 54
Reg. Dist. No. 410

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Blaine 070 — NOV 30 1967 — 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Rural, Carey
c. LENGTH OF STAY IN THIS PLACE: 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carey Lake, 1Mi. E. of Carey

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Ketchum 070
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
DEAN	ANTON	PIEROSE	Nov. 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Dec. 3, 1914	52				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pierose Maint. Corp.	06 Maintance	Los Angeles, California	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Nicholas Pierose	Yugoslavia	Pauline Brautovic	Yugoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW 2 4	558-44-2979	[signature]	Boise Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental Drowning — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

350X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT/ SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Carey Lake	Carey 13	Blaine 070	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
11	24	67	6 p.m.		Boat overturned while hunting

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. Scott Earle 583	Coroner 4	Sun Valley Idaho	11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/28/67	Ketchum Cemetery	Ketchum, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 29/67	Robert H. Wrightsper R.B.N.	Keith Bird Keith Bird	E-373

FIRM NAME: Bird Funeral Home, Hailey

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 1 1967

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4862
Local Reg. No. 133
Reg. Dist. No. 110

BIRTH NO.

RECEIVED DEC 18 1967

1. PLACE OF DEATH
a. COUNTY Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bonner General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint 091
d. STREET ADDRESS (If rural, give location) 311 1/2 Pine Street

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) W. 039 c. (Last) Shafer
4. DATE OF DEATH (Month) (Day) (Year) August 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married /	Nov. 13, 1884	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 17	Lumber	Minnesota	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
no record	no record	no record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	--	701-16-3175A	IDPA Records by LDM Jr	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute Myocardial Infarction	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Arteriosclerotic Heart Disease	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Diabetes Mellitus	5 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. I hereby certify that I attended the deceased from 2-22, 1966, to 8-17, 1967, that I last saw the deceased alive on 8-17, 1967, and that death occurred at 11:50 a m., from the causes and on the date stated above.

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Charles Smith MD 480 (Degree or title)	Sandpoint, Idaho	8-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Aug. 23, 1967	County Cemetery	Sandpoint Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 13, 1967	Phyllis M. Willetts	L. G. Moon, Jr.	E-501

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4863
Local Reg. No. 124
Reg. Dist. No. 110

BIRTH NO.

RECEIVED Bureau of Vital Statistics DEC 5 1967

1. PLACE OF DEATH
a. COUNTY: Bonner 090 — 5-05
b. CITY OR TOWN: Colburn
c. LENGTH OF STAY (in this place): minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION: Highway #95 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN: Bonners Ferry 110
d. STREET ADDRESS (If rural, give location): Star Route #1

3. NAME OF DECEASED (Type or Print): a. (First) GARY; b. (Middle) LYLE; c. (Last) HALVERSON

4. DATE OF DEATH: (Month) (Day) (Year) November 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: July 21, 1949

9. AGE (In years last birthday): 18 — If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 10

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Bonners Ferry, Idaho

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Milo A. Halverson — BIRTHPLACE: Larson, North Dakota

14. MOTHER'S MAIDEN NAME: Ruth Mary Gudbaur — BIRTHPLACE: Sagle, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-56-8590

17. INFORMANT'S OWN SIGNATURE: Milo Halverson — ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Massive accidental trauma — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Multiple fractures of the skull with chest and internal injuries

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway # 95 06

21c. (CITY, TOWN, OR TOWNSHIP) 13 Colburn (COUNTY) 090 Bonner (STATE) Idaho

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) Nov. 9, 1967 9 P. m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Deceased fell out of car and was crushed by it.

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Barry D. Nelson 583

23b. ADDRESS: Sandpoint, Idaho

23c. DATE SIGNED: 11/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/13/67

24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery

24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.:

REGISTRAR'S SIGNATURE: Phyllis Y. Tibbetts

25. EMBALMER: L. G. Moon, Jr. — LICENSE NO.: E-405

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4864
Local Reg. No. 128
Reg. Dist. No. 110

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 091 2-08
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 8 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint 091
d. STREET ADDRESS (If rural, give location): 311 Lavina

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): F.
c. (Last): Clement

4. DATE OF DEATH (Month) (Day) (Year): Nov. 15, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 4, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer - Farmer 10
10b. KIND OF BUSINESS OR INDUSTRY: Railroad - Own Farm
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John C. Clement — BIRTHPLACE: France
14. MOTHER'S MAIDEN NAME: Mary Sullivan — BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 518-05-2358 A
17. INFORMANT'S OWN SIGNATURE: Anna Clement — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1-2 dy

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic vascular disease —
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2/27, 1967, *to* 11/15, 1967, *that I last saw the deceased alive on* 11/14, 1967, *and that death occurred at* 8:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 471 (Degree or title)
23b. ADDRESS [signature] Idaho
23c. DATE SIGNED 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint, Idaho

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4865
Local Reg. No. 134
Reg. Dist. No. 110

BIRTH NO.

RECEIVED DEC 18 1967 4-03

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 091 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 3 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint - Rural 091
d. STREET ADDRESS (If rural, give location): Westmond

3. NAME OF DECEASED (Type or Print): a. (First) Herbert b. (Middle) I. c. (Last) Roe

4. DATE OF DEATH (Month) (Day) (Year): Nov. 16, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 23, 1890

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sawmill Operator 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Cass Roe
BIRTHPLACE: W. Virginia

14. MOTHER'S MAIDEN NAME: Rosie Clovis
BIRTHPLACE: W. Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 232-28-0526

17. INFORMANT'S OWN SIGNATURE: X Mrs Herbert I. Roe
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 week.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-10, 1961, *to* 11-16, 1967, *that I last saw the deceased alive on* 11-16, 1967, *and that death occurred at* 8:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Herbert Smith M.D.
23b. ADDRESS: 480 Sandpoint Idaho
23c. DATE SIGNED: 11-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery
24d. LOCATION (City, town, or county) (State): Hayden Lake, Idaho

DATE REC'D BY LOCAL REG.: Dec 13, 1967
REGISTRAR'S SIGNATURE: Phyllis H. Willette
25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form PH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4866
Local Reg. No. 126
Reg. Dist. No. 110

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
LENGTH OF STAY (in this place): 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint - Rural 091
d. STREET ADDRESS (If rural, give location): Westmond

3. NAME OF DECEASED (Type or Print): a. (First) James b. (Middle) Phillip c. (Last) Beers

4. DATE OF DEATH (Month) (Day) (Year): Nov. 16, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 6, 1878
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Beers — BIRTHPLACE: No record
14. MOTHER'S MAIDEN NAME: Evelyn Dudley Miller — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 517-12-0995
17. INFORMANT'S OWN SIGNATURE: Susie B. Beers — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Thrombophlebitis, legs — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

463X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]:
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1965, *to* Nov 16, 1967, *that I last saw the deceased alive on* Nov 16, 1967, *and that death occurred at* 9:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 327 (Degree or title) MD
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Absarokee Cemetery
24d. LOCATION (City, town, or county): Stillwater (State): Montana

DATE REC'D BY LOCAL REG.: Nov 27, 1967
REGISTRAR'S SIGNATURE: Phyllis G. Roberts
25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-62021

DUTIES:

DEC 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4867
Local Reg. No. 352
Reg. Dist. No.

BIRTH NO.

NOV 27 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 010 Boise
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-(Hwy. 15)
c. LENGTH OF STAY (in this place) In Transit 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 8 Miles So. Horseshoe Bend

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 810 Warm Springs Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Kenneth b. (Middle) W. 000 c. (Last) O'Leary

4. DATE OF DEATH (Month) Nov. (Day) 17 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Dec. 28, 1907

9. AGE (In years last birthday) 59 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lawyer 16

10b. KIND OF BUSINESS OR INDUSTRY Law

11. BIRTHPLACE (State or foreign country) Boise, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank O'Leary BIRTHPLACE Oregon

14. MOTHER'S MAIDEN NAME Belle Webster BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs Kenneth O'Leary ADDRESS Boise, Idaho

18. CAUSE OF DEATH 8854
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral injury — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Skull fracture — Immediate
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify) /

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) 13 Horseshoe Bend, Idaho (COUNTY) 080 (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) Nov 17, 1967 (Hour) 0 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2

21f. HOW DID INJURY OCCUR? Reported to have been thrown from auto

22. I hereby certify that I attended the deceased from not attended to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at 4 A. m., from the causes and on the date stated above.

23a. SIGNATURE Paul F. Miner 364 (Degree or title) MD.1

23b. ADDRESS 105 N. 8th St Boise, Idaho

23c. DATE SIGNED 11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2

24b. DATE 11-20-1967

24c. NAME OF CEMETERY OR CREMATORY Mtn. View Crematory

24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE Mrs. E. S. Robison

25. EMBALMER Daniel G. Gibson LICENSE NO. E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 26 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 15 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 18 1968

FEB 2 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

MAY 31 1973

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

APR 19 1978

JUN 10 1999

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4868
Local Reg. No. 125
Reg. Dist. No. 110

BIRTH NO.

RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonner 090
DEC 5 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coolin
c. LENGTH OF STAY (in this place): Bureau of Vital Statistics 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cavanaugh Bay Area 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Washington 48
b. COUNTY: Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spokane 555
d. STREET ADDRESS (If rural, give location): 707 E. Wabash

3. NAME OF DECEASED (Type or Print): a. (First) Bernard; b. (Middle) --; c. (Last) Vanmurden

4. DATE OF DEATH (Month) (Day) (Year): Nov. 18, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 26, 1911

9. AGE (In years last birthday): 56 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer 21

10b. KIND OF BUSINESS OR INDUSTRY: Edgecliff San.

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Vanmurden
BIRTHPLACE: Minnesota

14. MOTHER'S MAIDEN NAME: Lillian Olson
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 539-07-6082

17. INFORMANT'S OWN SIGNATURE: Ruth Vanmurden
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Barry D. Nelson 583 (Degree or title): Coroner 4

23b. ADDRESS: Sandpoint, Idaho

23c. DATE SIGNED: 11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Nov. 18, 1967

24c. NAME OF CEMETERY OR CREMATORY: Riplinger Funeral Home

24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: Nov. 27, 1967

REGISTRAR'S SIGNATURE: Phyllis M. Gillette

25. EMBALMER: Riplinger Funeral Home - Spokane, Wn.
LICENSE NO.

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 6 1967

DEC 19 1967

JAN 22 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4869
Local Reg. No. 127
Reg. Dist. No. 110

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 091 Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
LENGTH OF STAY (in this place) 3 1/2 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
d. STREET ADDRESS (If rural, give location) 1001 N. 5th

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) L. c. (Last) Grigg

4. DATE OF DEATH (Month) (Day) (Year) Nov. 18, 1967

5. SEX FeMale
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH March 31, 1881
9. AGE (In years last birthday) 86
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ira Search BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Rebekah McFarland BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 518-16-8727 D
17. INFORMANT'S OWN SIGNATURE Frances E. Cook ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 331X Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) and Respiratory Failure
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pneumonia / Diabetes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 25, 1958, *to* Nov 18, 1967, *that I last saw the deceased alive on* Nov 17, 1967, *and that death occurred at* 12:00 noon, *from the causes and on the date stated above.*

23a. SIGNATURE 471 (Degree or title)
23b. ADDRESS
23c. DATE SIGNED 11/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY McArthur Cemetery
24d. LOCATION (City, town, or county) Boundary County (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 1, 1967
REGISTRAR'S SIGNATURE
25. EMBALMER Dale G. Coffelt LICENSE NO. E-501
FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 5 - 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4870
Local Reg. No. 731
Reg. Dist. No. 110

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 091 Bonner
b. CITY OR TOWN Sandpoint
LENGTH OF STAY (in this place) 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint 091
d. STREET ADDRESS (If rural, give location) Sandpoint Manor

3. NAME OF DECEASED (Type or Print) a. (First) Nettie b. (Middle) M. c. (Last) Forrest
4. DATE OF DEATH (Month) (Day) (Year) Nov. 19, 1967
5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 26, 1900
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME William D. Coltham BIRTHPLACE No record
14. MOTHER'S MAIDEN NAME Bova Jane Shown BIRTHPLACE No record
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 485-05-6056
17. INFORMANT'S OWN SIGNATURE X Roy Forrest ADDRESS Sandpoint Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4427 Atherosclerotic Cardio

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Vascular renal disease
DUE TO (c) & Multiple Cerebral

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Vascular Accidents

INTERVAL BETWEEN ONSET AND DEATH
(a) [blank]
(b) [blank]
(c) [blank]
II. 10 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1965, *to* Nov 19, 1967, *that I last saw the deceased alive on* Nov 18, 1967, *and that death occurred at* 7:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE J Munson 382 (Degree or title) MD
23b. ADDRESS Sandpoint Ida
23c. DATE SIGNED 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 24, 1967
24c. NAME OF CEMETERY OR CREMATORY County Cemetery
24d. LOCATION (City, town, or county) Sandpoint (State) Idaho

DATE REC'D BY LOCAL REG. 12-4-67
REGISTRAR'S SIGNATURE Phyllis M. Gillett
25. EMBALMER Dale G. Coffelt
LICENSE NO. E-501
FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-55021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4871
Local Reg. No. 120
Reg. Dist. No. 110

RECEIVED

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonner 091 — DEC 5 1967 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau (township)): Sandpoint
c. LENGTH OF STAY (in this place): 2 1/2 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonner 091
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): N. Boyer Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Mary — b. (Middle) H. — c. (Last) White

4. DATE OF DEATH (Month) (Day) (Year): Nov. 20, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Feb. 17, 1890

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 77

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: H. P. Kalb — BIRTHPLACE: Virginia

14. MOTHER'S MAIDEN NAME: Lucy Smith — BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 534-16-1033A

17. INFORMANT'S OWN SIGNATURE / ADDRESS: [signature]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 months

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriosclerotic cardio-vascular -renal disease — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes mellitus — 18 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6/24, 1947, *to* 11/20, 1967, *that I last saw the deceased alive on* Nov. 20, 1967, *and that death occurred at* 6:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Helen E. Peterson 415 MD

23b. ADDRESS: Sandpoint, Idaho

23c. DATE SIGNED: 11/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 24, 1967

24c. NAME OF CEMETERY OR CREMATORY: Lakeview Cemetery

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: 12-4-67

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: L. G. Moon, Jr. — LICENSE NO.: E-405

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JUN 25 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4872
Local Reg. No. 129
Reg. Dist. No. 110

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 091 Bonner — DEC 5 1967 — 3-10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sandpoint
c. LENGTH OF STAY (In this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bonner General Hospital 039

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Colburn 090
d. STREET ADDRESS (If rural, give location) Box 12

3. NAME OF DECEASED (Type or Print) — a. (First) George — b. (Middle) -- — c. (Last) Reddiga

4. DATE OF DEATH (Month) (Day) (Year) Nov. 21, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH May 12, 1885
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Own Farm
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME No record — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME No record — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 518-05-4118
17. INFORMANT'S OWN SIGNATURE O B Pederson — ADDRESS

1533

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma, metastatic — INTERVAL BETWEEN ONSET AND DEATH 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma sigmoid Colon — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1966, 19__, *to* Nov 21, 1967, *that I last saw the deceased alive on* Nov 20, 1967, *and that death occurred at* 4:45A m., *from the causes and on the date stated above.*

23a. SIGNATURE O B Pederson — 327 (Degree or title) MD — 23b. ADDRESS Sandpoint Idaho — 23c. DATE SIGNED 11-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE Nov. 25, 1967 — 24c. NAME OF CEMETERY OR CREMATORY Pinecrest Cemetery — 24d. LOCATION (City, town, or county) Sandpoint (State) Idaho

DATE REC'D BY LOCAL REG. 12-4-67 — REGISTRAR'S SIGNATURE Phyllis G. Willetts — 25. EMBALMER L. G. Moon, Jr. — LICENSE NO. E-405

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-62021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4873
Local Reg. No. 368
Reg. Dist. No. 610

Certificate of Death

RECEIVED DEC 8 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 3-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF DAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 389 I Street

3. NAME OF DECEASED (Type or Print)
a. (First): WILLARD
b. (Middle): EUGENE
c. (Last): DALTON

4. DATE OF DEATH (Month) (Day) (Year): October 21, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 11, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cashier 25
10b. KIND OF BUSINESS OR INDUSTRY: U & I Sugar Co.
11. BIRTHPLACE (State or foreign country): Fielding, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Orlando Dalton — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Annie Welling — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. I
16. SOCIAL SECURITY NO.: 528 03 7923A
17. INFORMANT'S OWN SIGNATURE: Mrs W. E. Dalton — ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4 51 X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Massive G.I. Hemorrhage	8 hrs.
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Stress Ulcer(Peptic)	2 days
DUE TO (c)	Ruptured Aortic Aneurysm	5 days
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Arteriosclerotic Heart Disease	3 yrs

19a. DATE OF OPERATION: 10/16/67
19b. MAJOR FINDINGS OF OPERATION: Ruptured Abdominal Aortic Aneurysm
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-16, 1967, *to* 10-21, 1967, *that I last saw the deceased alive on* 10-21, 1967, *and that death occurred at* 9:00 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Warren N. Sutton MD 515
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 10/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/25/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 6-1967
REGISTRAR'S SIGNATURE: Anna Bredgin
25. EMBALMER: Jack A. Wood, Jr. — LICENSE NO. 396

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

1967 State File No. 4874
Local Reg. No. 327
Reg. Dist. No. 610

BIRTH NO.

RECEIVED AUG 6 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Green Chalet Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location): 305 West 2nd North

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
CHARLES	ANDREW	MIKESELL	Oct., 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 24 HRS.: Hours / Min.
Male	Caucasian	Married	19 April 1883	84		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer and Laborer
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hyrum, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew J. Mikesell	Manona, Iowa	Harriet Osborne	Hyrum, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Earl Mikesell — ADDRESS: St. Anthony, Idah

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease — Years

DUE TO (c) Generalized Arteriosclerosis — Years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19___ *to* Oct. 23, 1967, *that I last saw the deceased alive on* Oct. 21, 1967, *and that death occurred at* 8:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Usael Fell	M. D.	Rigby, Idaho	27 Oct. 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	27 Oct 67	Pineview Cemetery	Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 2-1967	Emma Budge	M. L. Hansen	E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4874
Local Reg. No. 327
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (01) — NOV 30 1967
b. CITY OR TOWN: Idaho Falls — Bureau of Vital Statistics
c. LENGTH OF STAY in this place: 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Greenview Chalet Rest Home 308

2. USUAL RESIDENCE (Where deceased lived? If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony 221
d. STREET ADDRESS (If rural, give location): 305 W. 2nd No.

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) ANDREW c. (Last) MIKESELL

4. DATE OF DEATH (Month) (Day) (Year): October 23, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 19, 1883

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer and Laborer

10b. KIND OF BUSINESS OR INDUSTRY: 04

11. BIRTHPLACE (State or foreign country): Hyrum, Utah

12. CITIZEN OF WHAT COUNTRY?: usa

13. FATHER'S NAME: Andrew J. Mikesell — BIRTHPLACE: Marrona, Iowa

14. MOTHER'S MAIDEN NAME: Harriet Osborne — BIRTHPLACE: Hyrum, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: M L Hansen — ADDRESS: St Anthony Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

42 00

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — years
DUE TO (c) Generalized Arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* Oct. 23, 1967, *that I last saw the deceased alive on* Oct. 21, 1967, *and that death occurred at* 8:40 AM., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Hall, 522 (Degree or title) M.D. 1
23b. ADDRESS: Rigby, Idaho
23c. DATE SIGNED: 10/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/27/67
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Idaho

DATE REC'D BY LOCAL REG.: 11/2/67
REGISTRAR'S SIGNATURE: Irma Bridges
25. EMBALMER: M L Hansen
LICENSE NO.: E 354
FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4875
Local Reg. No. 339
Reg. Dist. No. 6/D

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN Idaho Falls, (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hosp. 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ririe 100
d. STREET ADDRESS (If rural, give location) Ririe

3. NAME OF DECEASED (Type or Print): a. (First) BELVA b. (Middle) DEAN c. (Last) MILLER

4. DATE OF DEATH: (Month) (Day) (Year) Oct. 27, 1967

5. SEX: Fem.

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Nov. 11, 1899

9. AGE (In years last birthday): 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 00

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Poplar, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert W. Miller BIRTHPLACE: Ft. Douglas, Ut.

14. MOTHER'S MAIDEN NAME: Nellie Hawley, Pleasant Grove, Ut. BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE: Marguerite M. Mullenix ADDRESS: Ririe, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease with episodes of paroxysmal auricular fibrillation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Idiopathic convulsive seizures with possible mental deterioration.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 7, 19 57, *to* Oct. 27, 1967, *that I last saw the deceased alive on* Oct. 26, 19 67, *and that death occurred at* 1:50A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) L.K. Krantz M.D. 294

23b. ADDRESS 798 South Blvd. Idaho Falls, Idaho

23c. DATE SIGNED Nov. , 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Oct. 31, 1967

24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State) Idaho Falls, Bonn. Idaho

DATE REC'D BY LOCAL REG. Nov. 17-1967

REGISTRAR'S SIGNATURE Anna Budge

25. EMBALMER

LICENSE NO. E 387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4876
Local Reg. No. 348
Reg. Dist. No. 6/D

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 56yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, 101
d. STREET ADDRESS (If rural, give location): 155 West 18th St.

3. NAME OF DECEASED (Type or Print): a. (First) CARL b. (Middle) AUGUST c. (Last) JAEGER

4. DATE OF DEATH: (Month) (Day) (Year) Oct. 27, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 29, 1888

9. AGE (In years last birthday): 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer, ret. 04

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Benson, Minnesota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: August Jaeger, Germany

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Augusta Julia, Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-54-0372

17. INFORMANT'S OWN SIGNATURE: Julia Cook — ADDRESS: 675 Northrup, IF.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Emphysema — yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 7, 1967, *to* Oct. 26, 1967, *that I last saw the deceased alive on* Oct. 26, 1967, *and that death occurred at* 4:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L.K. Krantz, M.D. 294

23b. ADDRESS: 798 South Blvd. Idaho Falls, Idaho

23c. DATE SIGNED: Nov. , 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Oct. 29, 67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 17-67

REGISTRAR'S SIGNATURE: Anna Bulgin

25. EMBALMER: Dee Sullivan — LICENSE NO.: E 387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 11 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

3-5510

ADDITIONAL REMARKS by Physician.....

#16342

Certificate of Death

STATE OF IDAHO

State File No. 4877
Local Reg. No. 342
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 30 1967 Bureau of Vital Statistics

3-05

1. PLACE OF DEATH
a. COUNTY Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Annis 260
d. STREET ADDRESS (If rural, give location) Rte. #1 Lorenzo

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HARVEY	WILLIAM	GRAHAM	Oct. 31, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	Feb. 9, 1906	61		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Rudy, Idaho.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Silas W. Graham	Utah	Nettie Ann Severson	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None 0	518-10-7014	Ellen Graham	Rte. #1 Lorenzo, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5401 Perforated peptic ulcer — INTERVAL BETWEEN ONSET AND DEATH: 2 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES X NO

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Feb. 9, 1962, *to* Oct. 31, 1967, *that I last saw the deceased alive on* Oct. 30, 1967, *and that death occurred at* 5:05A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. N. Krantz, M.D. 294	798 South Blvd. Idaho Falls, Idaho	Nov. 13 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 3, 1967	Little Butte	Annis Jefferson Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 24 67	Emma Rudges	Bruce A. Eckersell Bruce A. Eckersell	E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4878
Local Reg. No. 335
Reg. Dist. No. 61

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Route # 5 Idaho Falls
c. LENGTH OF STAY (in this place): Unknown 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address or location): Route # 5 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Unknown
b. COUNTY: Unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Unknown 0-000
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print): a. (First) UNKNOWN b. (Middle) c. (Last)

4. DATE OF DEATH: (Month) November (Day) 3 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Male	Unknown	Unknown 0	Unknown	Unknown				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Unknown 00	Unknown	Unknown	Unknown

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Unknown	Unknown	None	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) APPARENTLY BURNED TO DEATH IN HOUSE TRAILER

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* ALCOHOL CONTENT OF STOMACH - 1.87 MG/CC; BLOOD ALCOHOL POSTMORTEM 2.1 MG/CC

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
ACCIDENT	00	13 IDAHO FALLS BONNEVILLE IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hazel L. McGaffey HAZEL L. MC GAFFEY, M. D. CORONER	583 2525 SOUTH BOULEVARD AVE	11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/7/67	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 14-67	Emma Rudges	Ralph M. Hood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4879
Local Reg. No. 334
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 3-01 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 308 C Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 296 Hill

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Harley	Enos	Johnson	November 4 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	November 28, 1915	42				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheet Metal Worker II	Construction	Arlington, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew C. Johnson	Iowa	Mayne Palmer	USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	Unknown	Information taken from city records	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HYPERTENSIVE CARDIOVASCULAR DISEASE — INTERVAL BETWEEN ONSET AND DEATH: SEVERAL YEARS

ANTECEDENT CAUSES — WITH CONGESTIVE HEART FAILURE

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — HYPOGLYCEMIA (15 MG%); ELECTROLYTE IMBALANCE SECONDARY TO ACUTE ALCOHOLISM Recent

Conditions contributing to the death but not related to the disease or condition causing death.

4437

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
NONE		IDAHO FALLS BONNEVILLE IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____ and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hazel L. McGaffey HAZEL L. McGAFFEY, M.D. CORONER 583	2525 SOUTH BOULEVARD, IDAHO FALLS	11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/8/67	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
NOV 14 67	Anna Bridgen	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Found dead in city jail. Abt 24 hrs after arrest for Intoxication.

H. M. Eaffer M.D.

Certificate of Death

STATE OF IDAHO

State File No. 4880
Local Reg. No. 337
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 522 College 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 522 College

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Arthur	Eugene	Peterson	November 4 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	March 10, 1918	49				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Businessman 23	Lounge	Lund, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur G. Peterson	Idaho	Luella T. Peterson	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1 3 42 01	Unknown	Arthur G. Peterson	Bancroft, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombus, recent anterior descending branch, left coronary artery

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary arteriosclerosis

DUE TO (c) Myocardial infarction, old.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. P. Mitchell M.D. 746	L.D.S. Hosp. Idaho Falls	11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/9/67	Monarch Memorial Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 14 '67	Emma Rudges	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 27 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 26 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

DISINTERMENT PERMIT

RECEIVED
BUREAU OF
VITAL STATISTICS
MAR 14 11 57 AM '72

STATE OF IDAHO
DEPARTMENT OF PUBLIC HEALTH
BOISE, IDAHO

APPLICATION HAVING BEEN MADE for the disinterment of the body of Arthur Eugene Peterson

now lying buried in Monarch Memory Gardens Cemetery, in the City or Town of Idaho Falls

County of Bonneville State of Idaho, who died on the 4 day of Nov., 1967, Aged 49 years ____ months ____ days, the cause of death being Thrombus, recent, anterior decending branch, Myocardial Inf. and not directly or indirectly by diphtheria; (membranous croup); scarlet fever; smallpox; leprosy; asiatic cholera; typhus fever; or yellow fever as shown by the certificate of death of said deceased, given by

Dr. Thomas Mitchell attending physician

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by Private private or railway conveyance

to Fielding Memorial Cemetery in the City or Town of Idaho Falls County of Bonneville

State of Idaho to take effect upon the approval by the local board of health of the City, Town, or County of

Bonneville it being understood and provided that nothing herein shall be deemed as contravening or in anywise modifying or releasing the Regulations of the Department of Public Health governing the Transportation of Corpses or the requirements for a Transportation permit, and all Transportation Companies and Common Carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed Embalmer in good standing. If the remains are to be removed from the cemetery they (including the disinterred casket), must be enclosed in a new metallic lined outer case before removal.

Given under my hand and Seal of the Department of Public Health at Boise, Idaho,

this 17th day of March, A.D. 19 72.

permit issued to:

Wood Funeral Home
Jack A. Wood, Jr.
Idaho Falls, Idaho

W. W. Benson

by [signature] Director, ~~Division of Vital Statistics~~

The foregoing application for disinterment and removal is hereby approved by the local Board of Health of the City, Town or County of _____ State of Idaho, this _____ day of _____ 19____.

_____
Health Officer

Form DPH-48019

Certificate of Death

STATE OF IDAHO

State File No. 4881
Local Reg. No. 341
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH 101
a. COUNTY Bonneville 1-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) Yr. 6 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenville Nursing Home 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls 101
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) Lewis
c. (Last) Shaw

4. DATE OF DEATH (Month) (Day) (Year) November 7 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH August 15, 1882
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor & Carpenter
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Salem, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Osmond Weilding Shaw — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Melissa Ann Atwood — BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. unknown
17. INFORMANT'S OWN SIGNATURE Rosa Hessner — ADDRESS Driggs, Idaho

18. CAUSE OF DEATH 4918
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 5 d.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Cardiovascular Dis. 10 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1958, to Nov. 5, 1967, that I last saw the deceased alive on Nov. 5, 1967, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Pauline Singel, M.D. 359 (Degree or title)
23b. ADDRESS 1544-4th Idaho Falls, Ida.
23c. DATE SIGNED 11/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/11/67
24c. NAME OF CEMETERY OR CREMATORY Cache Clawson Cemetery
24d. LOCATION (City, town, or county) Tetonia (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 16-1967
REGISTRAR'S SIGNATURE Anna Budgee
25. EMBALMER Ralph M. Wood Ralph M. Wood
LICENSE NO. 413

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4882
Local Reg. No. 343
Reg. Dist. No. 610

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls 101
d. STREET ADDRESS (If rural, give location) 1525 Curtis Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Ethelyn
b. (Middle) Miller
c. (Last) Abbott

4. DATE OF DEATH (Month) (Day) (Year) Nov 7, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 7 Oct 1909

9. AGE (In years last birthday) 58
IF UNDER 1 YEAR: Months 1 Days 0
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Fresno, California

12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME William Miller
BIRTHPLACE ?

14. MOTHER'S MAIDEN NAME Martha ?
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Ethelyn Miller Abbott
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1748 Brain metastases
INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adenocarcinoma of Uterus — 3 Months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION above

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Harvey A. Hatch M.D. (Degree or title) 208

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED Nov. 14, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 13 1967

24c. NAME OF CEMETERY OR CREMATORY Fielding Memorial Park

24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. Nov 17-67

REGISTRAR'S SIGNATURE Anna Bridges

25. EMBALMER Leo A. Williams

LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 10 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4883
Local Reg. No. 347
Reg. Dist. No. 611

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 100 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ririe (rural)
c. LENGTH OF STAY (in this place) min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 5 mi. S.E. of Ririe 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 5-05 Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ririe (rural) 260
d. STREET ADDRESS (If rural, give location) Heise

3. NAME OF DECEASED (Type or Print) a. (First) MICHAEL b. (Middle) GREGORY c. (Last) CARR

4. DATE OF DEATH (Month) (Day) (Year) Nov. 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH June 3, 1950
9. AGE (In years last birthday) 17 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) Glendale, Calif.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lloyd B. Carr | BIRTHPLACE Montana
14. MOTHER'S MAIDEN NAME Martha S. Keaton | BIRTHPLACE California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service) None 0
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Lloyd B. Carr | ADDRESS Ririe, Idaho.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) AVULSION, SCALP, SKULL AND UPPER CEREBRUM — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) GUNSHOT WOUND TO HEAD, HIGH POWER RIFLE INSTANT
AT CLOSE RANGE

DUE TO (c) ACCIDENTAL DISCHARGE WHILE HUNTING FROM CAR.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) ACCIDENT
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 00
21c. (CITY, TOWN, OR TOWNSHIP) RIRIE 13 (COUNTY) BONNEVILLE (STATE) IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 10:30 P.M., from the causes and on the date stated above.*

23a. SIGNATURE Hazel L. McGaffey, M.D. 583 (Degree or title) Coroner
23b. ADDRESS 4 Idaho Falls, Idaho.
23c. DATE SIGNED 11/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Transportation
24b. DATE 3. 11/9/1967
24c. NAME OF CEMETERY OR CREMATORY Garden Grove
24d. LOCATION (City, town, or county) Garden Grove (State) California

DATE REC'D BY LOCAL REG. Nov 24-67
REGISTRAR'S SIGNATURE Anna Budge
25. EMBALMER Bruce A. Eckersell
LICENSE NO. E-404

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Eckersell Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4884
Local Reg. No. 343
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
NOV 22 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 3-07
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 1090 North Boulevard

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) LeRoy c. (Last) Tanner Jr.

4. DATE OF DEATH (Month) (Day) (Year): November 9 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 20, 1907

9. AGE (In years last birthday): 60
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Chester, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William LeRoy Tanner Sr. BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Katherine Lauder BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 552 030 306A

17. INFORMANT'S OWN SIGNATURE: Beverly V. Duncan ADDRESS: Idaho Falls, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

253X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): possible Myxedema Coma ?
INTERVAL BETWEEN ONSET AND DEATH: Week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Arteriosclerotic Heart Disease

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug, 1967, *to* Nov 9, 1967, *that I last saw the deceased alive on* Nov 9, 1967, *and that death occurred at* 10:30 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Byron T Weeks MD 556
23b. ADDRESS: 1585 So Boulevard
23c. DATE SIGNED: 11-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/13/67
24c. NAME OF CEMETERY OR CREMATORY: Parker Cemetery
24d. LOCATION (City, town, or county) (State): Fremont County Idaho

DATE REC'D BY LOCAL REG.: Nov 16 1967
REGISTRAR'S SIGNATURE: Anna Rudges
25. EMBALMER: Ralph M. Wood Ralph M Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 30 1967
DEC 28 1967
JAN 11 1968
JAN 07 1991
SEP 23 1994
APR 03 2015

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4885
Local Reg. No. 357
Reg. Dist. No. 616

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 NOV 30 1967
b. CITY OR TOWN Idaho Falls, Idaho (If outside corporate limits, write RURAL and give Bureau of Vital Statistics) c. LENGTH OF STAY IN THIS PLACE 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Greenview Chalet Nursing Home 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg 331
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) MABEL b. (Middle) BLAIR c. (Last) BROWNING

4. DATE OF DEATH (Month) (Day) (Year) November 9, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH December 16, 1882

9. AGE (In years last birthday) 84 If UNDER 1 YEAR Months Days If UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Evanston, Wyoming

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Henry Blair BIRTHPLACE Englowsilion, Glamargaur, Wales

14. MOTHER'S MAIDEN NAME Charlotte Bateman BIRTHPLACE Stifford, Staffs. England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Elmer F. Brownning ADDRESS Idaho Falls, Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4928

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Cerebral arteriosclerosis
Conditions contributing to the death but not related to the disease or condition causing death Arteriosclerotic heart disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 18 Jan, 1967, *to* 8 Nov, 19 67, *that I last saw the deceased alive on* 8 Nov, 1967, *and that death occurred at* 1400 m., *from the causes and on the date stated above.*

23a. SIGNATURE Jens O. Johnson 262 (Degree or title) MD

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED 13 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11/13/67

24c. NAME OF CEMETERY OR CREMATORY Little Butte

24d. LOCATION (City, town, or county) (State) Annis Jefferson Idaho

DATE REC'D BY LOCAL REG. Nov 29, 1967

REGISTRAR'S SIGNATURE Irma A. Burgess

25. EMBALMER Kenneth R. Flamm

LICENSE NO. E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4886
Local Reg. No. 344
Reg. Dist. No. 610

67-10676
BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 825 Royal

3. NAME OF DECEASED (Type or Print): a. (First) Scott b. (Middle) Allen c. (Last) Smart

4. DATE OF DEATH: November 9 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: November 8, 1967

9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days: 1 — IF UNDER 24 HRS. Hours: 4 / Min.: 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 00

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Gilfred Smart Jr. — BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Marjorie Ann Gleave — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Gilfred Smart Jr. ADDRESS: Idaho Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7730 Hyaline Membrane Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): M.D. — **23b. ADDRESS**: Idaho Falls, Idaho — **23c. DATE SIGNED**: 11/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 11/10/67 — **24c. NAME OF CEMETERY OR CREMATORY**: Rose Hill Cemetery — **24d. LOCATION** (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Nov. 16-1967 — **REGISTRAR'S SIGNATURE**: [signature]

25. EMBALMER: Ralph M. Wood [signature] — **LICENSE NO.**: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4887
Local Reg. No. 33
Reg. Dist. No. 20

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics 3-03

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby 260
d. STREET ADDRESS (If rural, give location): Route # 2 Box 214A

3. NAME OF DECEASED (Type or Print): a. (First) Charles b. (Middle) Melvin c. (Last) Cleverley

4. DATE OF DEATH (Month) (Day) (Year): November 10 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married ?

8. DATE OF BIRTH: August 11, 1911

9. AGE (In years last birthday): 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Shelton, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clarence Cleverley — BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Rozella May Hicks — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE: Ethel Cleverley — ADDRESS: Rigby, Idaho Rt. 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Thrombosis
DUE TO (c) ASHD

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1966, *to* Nov. 10, 1967, *that I last saw the deceased alive on* Nov 10, 1967, *and that death occurred at* 8:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Byron T. Weeks MD — **23b. ADDRESS**: 1585 So. Boulevard — **23c. DATE SIGNED**: Nov 13, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 11/15/67 — **24c. NAME OF CEMETERY OR CREMATORY**: Ririe Shelton Cemetery — **24d. LOCATION** (City, town, or county) (State): Ririe Idaho

DATE REC'D BY LOCAL REG.: Nov 16-1967 — **REGISTRAR'S SIGNATURE**: Anna Burgess

25. EMBALMER: Ralph M. Wood Ralph M. Wood — **LICENSE NO.**: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 25 1979

JUN 13 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4888
Local Reg. No. 354
Reg. Dist. No. 611

Certificate of Death

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DOA. Sacred Heart Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley 060
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Merlin
b. (Middle): LLOyd 000
c. (Last): Godfrey

4. DATE OF DEATH (Month) (Day) (Year): 11 10 1967

5. SEX: Male
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept 1, 1913
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Public Works Director
10b. KIND OF BUSINESS OR INDUSTRY: 08
11. BIRTHPLACE (State or foreign country): Ucon Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Josiah Godfrey — BIRTHPLACE: North Ogden Utah
14. MOTHER'S MAIDEN NAME: Gunda Belletta Petersen — BIRTHPLACE: Hyrum, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-07-2405
17. INFORMANT'S OWN SIGNATURE: Norman Godfrey — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*
(a) OCCLUSION BY THROMBUS, RECENT, CIRCUMBLEX BRANCH, LEFT CORONARY ARTERY

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROSIS, SEVERE WITH STENOSIS CORONARY ARTERIES GENERALLY
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
MYOCARDIAL FIBROSIS, DUE TO OLD ISCHEMIC CHANGES

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NONE
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS BONNEVILLE IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hazel L McGaffey
583 HAZEL L. MC GAFFEY, M. D. CORONER 4
23b. ADDRESS: IDAHO FALLS, IDA 2525 SOUTH BOULEVARD AVE
23c. DATE SIGNED: 11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-14-67
24c. NAME OF CEMETERY OR CREMATORY: Hill Crest
24d. LOCATION (City, town, or county) (State): Shelley, Bingham Idaho

DATE REC'D BY LOCAL REG.: Nov 22-67
REGISTRAR'S SIGNATURE: Anna Budgen
25. EMBALMER: L M Nalder
LICENSE NO.: E275

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Nalder Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 5 1967

DEC 07 2009

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4889
Local Reg. No. 348
Reg. Dist. No. 610

928

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN Idaho Falls
LENGTH OF STAY (In this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bingham 060
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) R#1 Shelley, Idaho
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Orson	Vernon	Kelsey	Nov	10	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept 30 1913	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Shelley, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Amos Kelsey	Wyoming	Serena Jensen	Milburn Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 519-09-1656
17. INFORMANT'S OWN SIGNATURE Melvin Kelsey ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1967 Fibro sarcoma Rt femur
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Ca w/ Mets to lung, pulmonary & pleura -
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/15/ , 19 60, *to* Nov. 10, , 19 67, *that I last saw the deceased alive on* Nov 10, , 19 67 *and that death occurred at* 5:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE G. W. Corbett, M.D. 104 (Degree or title)
23b. ADDRESS 798 South Blvd. Idaho Falls, Idaho
23c. DATE SIGNED Nov. , 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 14 67	Mt. View Crest	Shelley, Bingham, Idaho

DATE REC'D BY LOCAL REG. Nov 14-67
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Daryl L. Nalder LICENSE NO. 444
FIRM NAME: Nalder's Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 23 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4890
Local Reg. No. 349
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

BIRTH NO. 67-10690

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

1. PLACE OF DEATH 101
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 121 Fourth St.

3. NAME OF DECEASED (Type or Print)
a. (First): Baby
b. (Middle): Weitfle
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Nov 10, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): infant /
8. DATE OF BIRTH: Nov 10, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min. 1-2

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Robert Brent Weitfle
BIRTHPLACE: Idaho Falls, Ida.
14. MOTHER'S MAIDEN NAME: Karen Eunice Wilkie
BIRTHPLACE: Idaho Falls, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Robert B. Weitfle
ADDRESS: Idaho Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 776X Prematurity

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 078 (Degree or title): Jack R. Carey M.D.
23b. ADDRESS: Idaho Falls, Ida
23c. DATE SIGNED: 11/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 11/10/67
24c. NAME OF CEMETERY OR CREMATORY: Private
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 24-67
REGISTRAR'S SIGNATURE: Anna Bridgio
25. EMBALMER: Leo A Williams
LICENSE NO.: E-319

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended December 19, 1967

Certificate of Death

STATE OF IDAHO

State File No. 4891
Local Reg. No. 350
Reg. Dist. No. 610

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 371 Hill Street

3. NAME OF DECEASED (Type or Print): a. (First) Roland; b. (Middle) Asher; c. (Last) Stewart

4. DATE OF DEATH (Month) (Day) (Year): November 12, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: September 20, 1898
9. AGE (In years last birthday): 69 | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 11
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Iona, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James B. Stewart — BIRTHPLACE: USA
14. MOTHER'S MAIDEN NAME: Almeda Evans — BIRTHPLACE: USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 519-09-1868
17. INFORMANT'S OWN SIGNATURE: Alta E. Stewart — ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease — Years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Generalized Arteriosclerosis — Years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-12, 19 67, *to* 11-12, 19 67, *that I last saw the deceased alive on* 11-12-, 19 67, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: G. C. Waid, M.D. 546 (Degree or title) /
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 11-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial /
24b. DATE: 11-15-67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov 21, 1967
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood
LICENSE NO.: 413

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Wood Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

State of Idaho } ss.
County of Bonneville }

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Roland Asher Stewart (Name on Original Certificate) who died (Was Born or Died) on 11/12/1967 (Date of Event)
in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by discharge records (Bible Record, Insurance Policy, Etc.) prepared on 3/1/1919 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
15. Was deceased ever in US Armed Forces	No	yes World War I

Subscribed and sworn to before me this 9th day of December, 1967

Ralph M. Hood

Notary Public, residing at Idaho Falls, Idaho

My commission expires 11/20/1970

(Seal)

Signed Blanche D. Wood
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

273 North Ridge Ave Idaho Falls, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Bonneville }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 9th day of December, 1967

Ralph M. Hood

Notary Public, residing at Idaho Falls, Idaho

My commission expires 11/20/1970

(Seal)

Signed E. Annette Wood
(Signature of Any Credible Person)

273 North Ridge Ave Idaho Falls, Idaho
(Street Address, City, State)

FORM DH 80-155

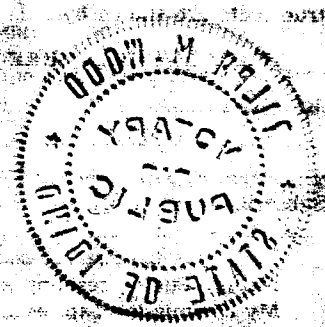
NOTARY
PUBLIC
STATE OF IDAHO

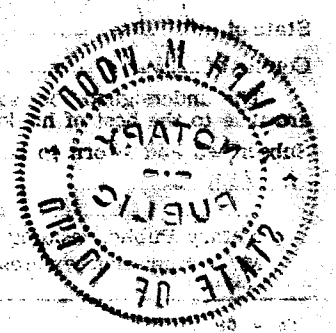
NOTARY
PUBLIC
STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No.
Local Reg. No. 350
Reg. Dist. No. 610

BIRTH NO.

NOV 30 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Bonneville

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

c. LENGTH OF STAY (In this place): 1 day

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bonneville

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

d. STREET ADDRESS (If rural, give location): 371 Hill Street

3. NAME OF DECEASED (Type or Print)

a. (First): Roland

b. (Middle): Asher

c. (Last): Stewart

4. DATE OF DEATH (Month) (Day) (Year): November 12 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: September 20, 1898

9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Iona, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James B. Stewart — BIRTHPLACE: USA

14. MOTHER'S MAIDEN NAME: Almeda Evans — BIRTHPLACE: USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-09-1868

17. INFORMANT'S OWN SIGNATURE: Alta E. Stewart — ADDRESS: Idaho Falls, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease — Years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Generalized arteriosclerosis — Years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-12, 1967, *to* 11-12, 1967 *that I last saw the deceased alive on* 11-12, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] no

23b. ADDRESS: Idaho Falls, Ida

23c. DATE SIGNED: 11/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/15/67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 21-67

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Ralph M. Wood [signature] — LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 11 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4892
Local Reg. No. 557
Reg. Dist. No. 610

Certificate of Death

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 101
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 285 1st Street

3. NAME OF DECEASED (Type or Print)
a. (First): Heber
b. (Middle): Alvin
c. (Last): Robison

4. DATE OF DEATH (Month) (Day) (Year): November 15 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: December 24, 1886
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer & Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming & Ranching
11. BIRTHPLACE (State or foreign country): Lyman, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Heber C. Robison — BIRTHPLACE: USA
14. MOTHER'S MAIDEN NAME: Sophia Foss — BIRTHPLACE: USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 26 2290
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few hours.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Congestive Heart Failure
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Uremia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 13 Nov, 1967, *to* 15 Nov, 1967, *that I last saw the deceased alive on* 15 Nov, 1967 *and that death occurred at* 7:00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 503
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 18 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/18/67
24c. NAME OF CEMETERY OR CREMATORY: Iona Cemetery
24d. LOCATION (City, town, or county): Iona (State): Idaho

DATE REC'D BY LOCAL REG.: Nov. 25-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Ralph M. Wood [signature] — LICENSE NO. 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 23 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 15 1992

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-10707 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4893
Local Reg. No. 3354
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 NOV 30 1967 0-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place) 0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, Idaho 101
d. STREET ADDRESS (If rural, give location) 433 1/2 Maple

3. NAME OF DECEASED (Type or Print) a. (First) (infant) b. (Middle) c. (Last) BERRY

4. DATE OF DEATH (Month) (Day) (Year) Nov. 15 - 1967

5. SEX Female

6. COLOR OR RACE Caucasoid

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Nov. 15, 1967

9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 1 Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 00

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ronold Lee Berry BIRTHPLACE Perry, Oklahoma

14. MOTHER'S MAIDEN NAME Rita Ridley, BIRTHPLACE Powell, Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Ronald Lee Berry ADDRESS 433 1/2 Maple, IF

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7615 Placenta Previa Abruption with hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ~~Premature~~ SW
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Prematurity

19a. DATE OF OPERATION 11-15-67

19b. MAJOR FINDINGS OF OPERATION None

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-15, 1967, *to* 11-15, 1967, *that I last saw the deceased alive on* 11-15, 19 67, *and that death occurred at* 7:30 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD 779

23b. ADDRESS 9th + D Idaho Falls Idaho

23c. DATE SIGNED 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 16, 1967

24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

24d. LOCATION (City, town, or county) Idaho Falls, Idaho (State)

DATE REC'D BY LOCAL REG. Nov 20-67

REGISTRAR'S SIGNATURE Anna Bridges

25. EMBALMER, Bruce Sullivan LICENSE NO. E-387

FIRM NAME: Buck Funeral HOme

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4894
Local Reg. No. 356
Reg. Dist. No. 611

RECEIVED NOV 30 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Bonneville 1-19 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rt. #3, Ida. Falls — c. LENGTH OF STAY (in this place): 19yrs — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. ##3, 7mi E. Ida. Falls 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Bonneville — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101 — d. STREET ADDRESS (If rural, give location): Rt#3 Box 195

3. NAME OF DECEASED (Type or Print) — a. (First): BILLIE — b. (Middle): JEAN — c. (Last): ROTH

4. DATE OF DEATH (Month) (Day) (Year): Nov. 18, 1967

5. SEX: Female

6. COLOR OR RACE: Caucasoid

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Sept. 22, 1948

9. AGE (In years last birthday): 19 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: College

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Roth — BIRTHPLACE: Russia

14. MOTHER'S MAIDEN NAME: Inez Elizabeth Carlson, Ida. Falls, Ida. — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-64-3637

17. INFORMANT'S OWN SIGNATURE: Wm Roth — ADDRESS: Rt. #3, Ida. Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 1992 Sarcoma of thigh

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): & lung metastases

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 1 yr

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 1967, *to* Nov 18 19 67, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 8a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ken Hansen MD — (Degree or title): 200 — 23b. ADDRESS: Idaho Falls, Ida — 23c. DATE SIGNED: 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: Nov. 22, 67 — 24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery — 24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Nov. 28 1967 — REGISTRAR'S SIGNATURE: Emma Rodgers — 25. EMBALMER: Bill Sullivan — LICENSE NO.: E-387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 4895
Local Reg. No. 352
Reg. Dist. No. 611

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route # 2 (000)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ririe (100)
d. STREET ADDRESS (If rural, give location): 625 2nd East Box 363

3. NAME OF DECEASED (Type or Print): a. (First) Donald; b. (Middle) Keveren; c. (Last) Summers

4. DATE OF DEATH: (Month) (Day) (Year): November 18 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: November 1, 1931

9. AGE (In years last birthday): 36
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Rigby, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Arthur Claud Summers
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Lillian Ruth Keveren
BIRTHPLACE: Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Korean 7

16. SOCIAL SECURITY NO.: 518 30 6800

17. INFORMANT'S OWN SIGNATURE: Marlene M. Summers
ADDRESS: Ririe, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): CORONARY STENOSIS, CALCIFIC
INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ARTERIOSCLEROSIS, SEVERE, CORONARY ARTERIES
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: (FAMILY HISTORY OF DIABETES)

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NONE
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS BONNEVILLE IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): HAZEL L. MC CAFFEY, M. D. CORONER
23b. ADDRESS: 2525 SOUTH BOULEVARD, IDAHO FALLS
23c. DATE SIGNED: 11/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/21/67
24c. NAME OF CEMETERY OR CREMATORY: Pioneer Cemetery
24d. LOCATION (City, town, or county) (State): Rigby Idaho

DATE REC'D BY LOCAL REG.: Nov. 28-67
REGISTRAR'S SIGNATURE:
25. EMBALMER: Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 19 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 2 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4896
Local Reg. No. 353
Reg. Dist. No. 610

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 1-00
b. CITY OR TOWN: Idaho Falls
LENGTH OF STAY (in this place): Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 247 Broadway 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls 101
d. STREET ADDRESS (If rural, give location): 247 Broadway

3. NAME OF DECEASED (Type or Print): a. (First) Arlynn b. (Middle) Merten c. (Last) Ashment

4. DATE OF DEATH (Month) (Day) (Year): November 19 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: October 22, 1898
9. AGE (In years last birthday): 69
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Richmond, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Ashment BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Catherine Ann Bratton BIRTHPLACE: California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 520 20 6038
17. INFORMANT'S OWN SIGNATURE: Mrs Vella Krogh[illegible] ADDRESS: Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

490X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar pneumonia, R lung.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] Mitchell 746 (Degree or title) M.D.
23b. ADDRESS: L.D.S. Hosp. Idaho Falls Idaho
23c. DATE SIGNED: 11/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/22/67
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Nov. 25-67
REGISTRAR'S SIGNATURE: Emma Rudges
25. EMBALMER: Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4897
Local Reg. No. 358
Reg. Dist. No. 6/D

BIRTH NO.

NOV 30 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville (101)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital (042)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville (101)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 268 Short St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ray	Arvid	Engstrom	Nov 21, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
male	white	widowed 2	28 May 1913	54	5 mo 3	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
06	Idaho Potato Growers	Idaho Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Victor Engstrom	Sweden	Ida Elm	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Elmer Engstrom	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1930 Asbestosis of lungs — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
1963	Asbestosis	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Idaho Falls Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19 57, *to* ____, 19 67, *that I last saw the deceased alive on* 11-19, 19 67 *and that death occurred at* 6 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Idaho Falls Ida	11-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	25 Nov 1967	Rosehill Cemetery	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 29-67	Irma Bridges	Leo A. Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4898
Local Reg. No. 364
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Bonneville — 101 DEC 8 1967 — 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Greenview Chalet 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby (rural) — 260
d. STREET ADDRESS (If rural, give location): Rte. #1

3. NAME OF DECEASED (Type or Print): a. (First) ANNIE — b. (Middle) JOHANNA — c. (Last) CUTLER

4. DATE OF DEATH (Month) (Day) (Year): Nov. 21, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug. 25, 1884

9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Lakeshore, Utah.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Anders Christian Thompson — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Lisa Christopherson — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None 0

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Rte. #1 — ADDRESS: Rigby, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage (Stroke) — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease — years

DUE TO (c) Seneral Arteriosclerosis — years.

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma Sigmoid Inoperable — 1 year

4200

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: none performed

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1967, *to* Nov. 21, 1967, *that I last saw the deceased alive on* Nov. 21, 1967, *and that death occurred at* 5:10 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Asael Tall, 522 (Degree or title) M.D. 1

23b. ADDRESS: Rigby, Idaho.

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 25, 1967

24c. NAME OF CEMETERY OR CREMATORY: Rigby Pioneer

24d. LOCATION (City, town, or county) (State): Rigby Jefferson Idaho

DATE REC'D BY LOCAL REG.: Dec. 4 1967

REGISTRAR'S SIGNATURE: Emma Bridges

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 30 1967 Bureau of Vital Statistics

State File No. 4899
Local Reg. No. 359
Reg. Dist. No. 611

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural (Union)
LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg 331
d. STREET ADDRESS (If rural, give location) 48 South 3rd West.

3. NAME OF DECEASED (Type or Print) a. (First) ELWOOD b. (Middle) c. (Last) LEATHAM

4. DATE OF DEATH (Month) (Day) (Year) November 22, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 16, 1919
9. AGE (In years last birthday) 48 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rexburg, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles Spence Leatham BIRTHPLACE Wellsville, Utah
14. MOTHER'S MAIDEN NAME Maud Amelia Peterson BIRTHPLACE Minneapolis, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War II 4
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Phyllis Leatham ADDRESS Rexburg, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MULTIPLE FRACTURES AND SEVERE TRAUMA TO HEAD AND FACE — INTERVAL BETWEEN ONSET AND DEATH: INSTANT

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) SECONDARY TO AUTO-TRUCK COLLISION ON HITT ROAD AND RURAL CROSS ROAD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) ACCIDENT
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HITT ROAD N.E. OF 06
21c. (CITY, TOWN, OR TOWNSHIP) IDAHO FALLS 13 (COUNTY) BONNEVILLE 101 (STATE) IDAHO
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Hazel L. McGaffey (Degree or title) M. D. CORONER 583
23b. ADDRESS 2525 SOUTH BOULEVARD IDAHO FALLS
23c. DATE SIGNED 11/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/27/67
24c. NAME OF CEMETERY OR CREMATORY Rexburg
24d. LOCATION (City, town, or county) (State) Rexburg Madison Idaho

DATE REC'D BY LOCAL REG. Nov. 29-1967
REGISTRAR'S SIGNATURE Bonnie Rudges
25. EMBALMER Kenneth Flamm LICENSE NO. E347
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 5 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

FEB 8 1979

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4900
Local Reg. No. 369
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: 101 Bonneville — DEC 1 5 1967 — Bureau of Vital Statistics — 401
b. CITY OR TOWN: Idaho Falls — STAY (in this place): 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION: L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Jefferson
c. CITY OR TOWN: Menan — 260
d. STREET ADDRESS (If rural, give location): XXX

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JORDAN	GALE	CHRISTENSEN	Nov. 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Never married	July 25, 1958	9		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Student 03	School	Rigby, Idaho.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lynn L. Christensen	Grant, Idaho.	Blanche Bower	Chesterfield, Idaho.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No 0	None	Lynn L. Christensen	Menan, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Hemorrhage	2 hours
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Perforated left lung and Ruptured Spleen,	2 hours
DUE TO (c)	Pedestrian Car accident	2 hours
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Fractured skull, neck, left femur, left ribs	2 hours.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
/	Street 04	menan 13 Jefferson 260 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]	21f. HOW DID INJURY OCCUR?
Nov. 22, 1967 6 p.m.		Struck by Automobile

22. *I hereby certify that I attended the deceased from* Nov. 22, 1967 *to* Nov. 22, 1967, *that I last saw the deceased alive on* Nov. 22, 1967, *and that death occurred at* 7:50P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Orael Hall,	522 M.D.	Rigby, Idaho.	6 Dec. 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 25, 1967	Little Butte	Annis Jefferson Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 5-1967	Emma Bridges	Bruce A. Eckersell Bruce A. Eckersell	E-404

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Eckersell Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 14 2006

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4901
Local Reg. No. 367
Reg. Dist. No. 610

RECEIVED DEC 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 13 Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 1120 Terry

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Dalton	Wilburn	Strain	Nov 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	9 March 1905	62	8	15		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief of Police 08
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Okemah Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Strain	Oklahoma	Jodie Reese	Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Jack E Strain ADDRESS Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 2 wks.
DUE TO (c) Renal artery occlusion — 2 wks.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis Obliterans — 5 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-18, 1967, *to* 11-24, 19 67, *that I last saw the deceased alive on* 11-23, 19 67, *and that death occurred at* 8A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Warren A. Sutton 515	M.D.	1555 So Blvd Idaho Falls	11/30/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	27 Nov 1967	Fielding Memorial Park	Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 5 1967	Emma Rudge	Leo A Williams	E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63025

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4902
Local Reg. No. 365
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 8 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY IN (this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1604 Charlene 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1604 Charlene

3. NAME OF DECEASED (Type or Print): a. (First) Bertha b. (Middle) Irene c. (Last) Weight

4. DATE OF DEATH (Month) (Day) (Year): November 24 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: March 7, 1884

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 83

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Springville, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Loren H. Harmer
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Ellen Amelia Tew
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE: Irene T. Weight ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 43500 Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) General senility
DUE TO (c) Generalized arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. ~~Diabetes~~ ~~Arthritis~~

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: D. H. Baker 018 (Degree or title) M.D.
23b. ADDRESS: Idaho Falls
23c. DATE SIGNED: 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 11/24/67
24c. NAME OF CEMETERY OR CREMATORY: Salt Lake
24d. LOCATION (City, town, or county) (State): Salt Lake City Utah

DATE REC'D BY LOCAL REG.: Dec. 4 1967
REGISTRAR'S SIGNATURE: Anna Budge

25. EMBALMER: Ralph M. Wood Ralph M. Wood
LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 29 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 27 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4903
Local Reg. No. 366
Reg. Dist. No. 610

Certificate of Death

RECEIVED
DEC 8 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 9 1/2 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Greenview Chalet Nursing Home 308

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 352 8th

3. NAME OF DECEASED (Type or Print)
a. (First): Amelia
b. (Middle): R.
c. (Last): Tucker

4. DATE OF DEATH (Month) (Day) (Year): November 24 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 5, 1875
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Elmer, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Abram Dallas Banning — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Julia Ann Kessenger — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Mrs Lillie May Tate — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): cerebral infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. previous cerebral infarctions 3 yr.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 65, 1965, *to* death, 19__, *that I last saw the deceased alive on* 11-24, 1967, *and that death occurred at* 2 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. Wm Bridges MD 633
23b. ADDRESS: Idaho Falls
23c. DATE SIGNED: 11-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 11/28/67
24c. NAME OF CEMETERY OR CREMATORY: Arkansas City Cemetery
24d. LOCATION (City, town, or county) (State): Arkansas City Kansas

DATE REC'D BY LOCAL REG.: Dec. 4-1967
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood — Ralph M Wood — LICENSE NO. 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Amended January 23, 1968

Certificate of Death

STATE OF IDAHO

State File No. 4904
Local Reg. No. 362
Reg. Dist. No. 610

BIRTH NO. ———

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latterday Saints Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 375 East 14th Street

3. NAME OF DECEASED (Type or Print): a. (First) August; b. (Middle); c. (Last) Wakeman

4. DATE OF DEATH (Month) (Day) (Year): November 25, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: January 31, 1880

9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Vassa, Finland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fredirick Charles Wickman
BIRTHPLACE: Finland

14. MOTHER'S MAIDEN NAME: Maria Sophia Baugh
BIRTHPLACE: Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 32 1678

17. INFORMANT'S OWN SIGNATURE: Thelma Harris
ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS: Pulmonary Emphysema
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease — Years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11-24, 19 67, *to* 11-25-67, 19 ___, *that I last saw the deceased alive on* 11-25-67, 19 ___, *and that death occurred at* ___ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. C. Waid, M.D.

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-27-67

24c. NAME OF CEMETERY OR CREMATORY: Soda Springs Cemetery

24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: Dec 2, 1967

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss.
County of Bonneville

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for August Wakeman (Name on Original Certificate) who Died (Was Born or Died) on 11/25/67 (Date of Event)
in Idaho Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by family records (Bible Record, Insurance Policy, Etc.) prepared on 1/31/1880 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
1. Place of Death (d)	Sacred Heart Hospital	Latter day Saints Hospital
8. Birth Date	January 30, 1881	January 31, 1880
13. Father's name	Frederick Charles Wakeman	Frederick Charles Wickman

Subscribed and sworn to before me this 18 day of January, 1968

Ralph M. Hurd

Notary Public, residing at Idaho Falls, Idaho

My commission expires 11/20/1970

(Seal)

Signed [signature] (Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

976 Canyon Idaho Falls, Idaho (Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Bonneville

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 18 day of January, 1968

Ralph M. Hurd

Notary Public, residing at Idaho Falls, Idaho

My commission expires 11/20/1970

(Seal)

Signed Jackie A. Wood (Signature of Any Credible Person)

773 North Ridge Ave. Idaho Falls, Idaho (Street Address, City, State)

FORM DH 60-155

1-11-68 A

Certificate of Death

STATE OF IDAHO

State File No. 4904
Local Reg. No. 362
Reg. Dist. No. 610

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 008
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 375 East 14th Street

3. NAME OF DECEASED (Type or Print) a. (First) August b. (Middle) c. (Last) Wakeman

4. DATE OF DEATH (Month) (Day) (Year) November 25 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	January 30, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Vassa, Finland	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fredirick Charles Wakeman	Finland	Maria Sophia Baugh	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 32 1678	Thelma Wakeman	Idaho Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

490X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c) Pulmonary Emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-24, 1967, *to* 11-25, 1967, *that I last saw the deceased alive on* 11-25, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 546	Idaho Falls, Ida	11/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/27/67	Soda Springs Cemetery	Soda Springs Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 2 - 1967	Thelma Budge	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under DEC 29 1967 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures JAN 24 1968 of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4905
Local Reg. No. 363
Reg. Dist. No. 616

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter day Saints extended Unit

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 260 Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 227 S 2nd W

3. NAME OF DECEASED (Type or Print): a. (First) Bessie b. (Middle) May c. (Last) Everett

4. DATE OF DEATH (Month) (Day) (Year): November 26 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 29, 1887

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Moreland, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John F. Van Epps
BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Emma Johnson
BIRTHPLACE: Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 22 3061T

17. INFORMANT'S OWN SIGNATURE: Glen N. Everett
ADDRESS: Rigby, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma Colon, Metastatic — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Metastatic adenoca in mesentery stomach

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 24, 19da, *to* Nov 26, 1967, *that I last saw the deceased alive on* Nov 25, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. Carr MD (Degree or title) 081

23b. ADDRESS: 756 Orchard Ida Falls

23c. DATE SIGNED: 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/29/67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Dec. 2-1967

REGISTRAR'S SIGNATURE: Emma Rudges

25. EMBALMER: Ralph M. Wood Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4906
Local Reg. No. 378
Reg. Dist. No. 610

BIRTH NO.

DEC 15 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 101 Bonneville 311
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 620 Garfield

3. NAME OF DECEASED (Type or Print)
a. (First): Elmer
b. (Middle): G.
c. (Last): Goldman

4. DATE OF DEATH (Month) (Day) (Year): November 30 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 6, 1900
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tire Re-capper 06
10b. KIND OF BUSINESS OR INDUSTRY: Tire Company
11. BIRTHPLACE (State or foreign country): Pinkville, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Goldman — BIRTHPLACE: USA
14. MOTHER'S MAIDEN NAME: Emma Gernand — BIRTHPLACE: USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 24 0815
17. INFORMANT'S OWN SIGNATURE: Elsie Goldman — ADDRESS: Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1930

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cancer of brain (glioma) — INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 11-28-67
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-9, 1956, *to* 11-30 1967, *that I last saw the deceased alive on* 11-30, 1967 *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 156 [signature] M.D.
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/2/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Dec. 11-1967
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood [signature]
LICENSE NO.: 413

Federal Security Agency
United States Public Health Service
Form DH-6302
FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 16 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4907
Local Reg. No. 372
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 15 1967

1. PLACE OF DEATH
a. COUNTY 101 Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 540 North Boulevard

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 540 North Boulevard

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Zella	M.	Owen	November 30 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FeMale	White	Never Married 1	February 14, 1891	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher & Attendance Clerk	School 12	Ammon, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Daniel Warren Owen	Utah	Nancy Clementine Lowder	West Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 46 8929	Martha M. Curley	Idaho Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Senility — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. 20, 19 58, *to* Nov. , 19 67, *that I last saw the deceased alive on* , 1966, *and that death occurred at* 7:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L. K. Krantz, M.D.	798 South Blvd. Idaho Falls, Idaho	Dec. 11, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/4/67	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 12-'67	Anna Burgess	Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4908
Local Reg. No. 51-67
Reg. Dist. No. 100

BIRTH NO.

RECEIVED NOV 13 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 110 Boundary 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
LENGTH OF STAY (in this place) 17 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 116 b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print) a. (First) CLARENCE b. (Middle) (NONE) c. (Last) KNOPP

4. DATE OF DEATH (Month) (Day) (Year) November 3, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH September 14, 1886

9. AGE (In years last birthday) 81
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Alden, Illinois

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Albert Knopp BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Henrietta Manning BIRTHPLACE Whitewater, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 389-32-7275

17. INFORMANT'S OWN SIGNATURE Hospital Records ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4231

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. C.V.A.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept., 1967, *to* Nov. 3, 1967, *that I last saw the deceased alive on* 11/3, 1967, *and that death occurred at* 1:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE Gerald Dawson 150 (Degree or title) M.D.
23b. ADDRESS Bonners Ferry Idaho
23c. DATE SIGNED 11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/7/67
24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery
24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 8, 1967
REGISTRAR'S SIGNATURE Virgyle Stone
25. EMBALMER
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4909
Local Reg. No. 52-67
Reg. Dist. No. 100

Certificate of Death

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 110 Boundary 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 110
b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) P. O. Box #891

3. NAME OF DECEASED (Type or Print)
a. (First) MARION
b. (Middle) PRISCILLA
c. (Last) YANKEY

4. DATE OF DEATH (Month) (Day) (Year) November 8, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: October 5, 1923
9. AGE (In years last birthday): 44 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Homemaking
11. BIRTHPLACE (State or foreign country): Monroe, Michigan
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Harry A. Swartz — BIRTHPLACE: Oklahoma
14. MOTHER'S MAIDEN NAME: Priscilla Sullivan — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 367-20-4625
17. INFORMANT'S OWN SIGNATURE: Edward J. Yankey — ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH 415X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C.V.A. — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Myocarditis — years
DUE TO (c) Rheumatic heart dis. — "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hypertension

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 7, 1967, *to* Nov. 8, 1967, *that I last saw the deceased alive on* Nov. 8, 1967 *and that death occurred at* 1:45 A.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Frederick Dunne 150 (Degree or title) MD
23b. ADDRESS: Bonners Ferry Idaho
23c. DATE SIGNED: 11/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 11/9/67
24c. NAME OF CEMETERY OR CREMATORY: Rupp Funeral Home
24d. LOCATION (City, town, or county) (State): Monroe, Michigan

DATE REC'D BY LOCAL REG.: 11/12/67
REGISTRAR'S SIGNATURE: Virgila Stone
25. EMBALMER: [signature]
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 14 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 20 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4910
Local Reg. No. 53-67
Reg. Dist. No. 100

RECEIVED NOV 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 310
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 110
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Route #1, Box #43

3. NAME OF DECEASED (Type or Print): a. (First) PERRY b. (Middle) LEWIS c. (Last) EVERHART

4. DATE OF DEATH (Month) (Day) (Year): November 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	October 10, 1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Bennett, Nebraska	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis Everhart	Ohio	Elizabeth Mosher	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No —	519-09-4521	Edna M Everhart	Bonners Ferry, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: unk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Diabetes Mellitus, Pneumonia

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19 63 *to* 11/12, 19 67, *that I last saw the deceased alive on* 11/12, 19 67, *and that death occurred at* 3:55 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	153 MD	Bonners Ferry Ida	11/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/15/67	Grandview Cemetery	Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 17, 1967	Twyla Stone	[signature]	E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4911
Local Reg. No. 54-67
Reg. Dist. No. 100

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 110 Boundary 201
b. CITY OR TOWN Bonners Ferry (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place) 37 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 118 Boundary
c. CITY OR TOWN Bonners Ferry (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location) P. O. Box #449

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ANDREW	FRANK	TAFTE	November 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	12/4/1879	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Agriculture	Skjak, Norway	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-30-7409	Chris C. Tafte	Bonners Ferry Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial infarction	unknown
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	ASHD	20+ yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteriosclerosis	5 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
No		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
No		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* Nov, 1967, *that I last saw the deceased alive on* 11/11, 1967, *and that death occurred at* 7:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] MD (Degree or title)	Bonners Ferry	11/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/16/67	Forest Cemetery	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11/21/67	Verryla Stone	[signature]	E-453

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE.~~ The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4912
Local Reg. No. 56-67
Reg. Dist. No. 100

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

NOV 29 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 110 Boundary 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 1 hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Great Northern Railroad Track 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 27 Montana
b. COUNTY 555 Lewis-Clark
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Helena
d. STREET ADDRESS (If rural, give location) Monticello Apartments

3. NAME OF DECEASED (Type or Print)
a. (First) THOMAS
b. (Middle) NEIL
c. (Last) BELGARDE

4. DATE OF DEATH (Month) (Day) (Year) November 17, 1967

5. SEX Male
6. COLOR OR RACE Indian 3
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH January 28, 1916
9. AGE (In years last birthday) 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bartender 23
10b. KIND OF BUSINESS OR INDUSTRY Night Club
11. BIRTHPLACE (State or foreign country) Craig, Montana
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Louis Belgarde — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Mary Morrow — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 517-20-4390
17. INFORMANT'S OWN SIGNATURE Official Records — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

802X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Skull Fractures — INTERVAL BETWEEN ONSET AND DEATH Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fractured right elbow — Minutes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Great Northern Tracks 10
21c. (CITY, TOWN, OR TOWNSHIP) 13 Bonners Ferry — (COUNTY) 110 Boundary — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11/17/67 5:00 A. M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fell from moving railroad freight train.

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, *19*___, *to* _____, *19*___, *that I last saw the deceased alive on* _____, *19*___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE C.M. Callahan — 583 (Degree or title) Coroner 4
23b. ADDRESS Bonners Ferry, Idaho
23c. DATE SIGNED 11/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11/18/67
24c. NAME OF CEMETERY OR CREMATORY Hagler Funeral Home
24d. LOCATION (City, town, or county) Helena — (State) Montana

DATE REC'D BY LOCAL REG. 11-25-67
REGISTRAR'S SIGNATURE Twyla Stone
25. EMBALMER Charles O. Malone
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 29 1967

DEC 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4913
Local Reg. No. 58-67
Reg. Dist. No. 100

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 10 Boundary 023
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
LENGTH OF STAY (in this place) 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 13 Idaho
b. COUNTY 10 Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) 807 Oak Street

3. NAME OF DECEASED (Type or Print): a. (First) JOSEPHINE b. (Middle) MARIE c. (Last) DION

4. DATE OF DEATH (Month) (Day) (Year): November 19, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: June 13, 1871

9. AGE (In years last birthday): 96
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Homemaking

11. BIRTHPLACE (State or foreign country): Curran, Ontario, Canada

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Rudy Vallee
BIRTHPLACE: St. Eugene, Ontario, Can.

14. MOTHER'S MAIDEN NAME: Marguerite Cleiment
BIRTHPLACE: Ontario, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: 519-60-9678J1

17. INFORMANT'S OWN SIGNATURE: Emile W. Dion
ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5721 Intracranial hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 6 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 5 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cardiovascular Disease 20 yrs

19a. DATE OF OPERATION: NO

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NO

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): NO m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 11/19, 1967, *that I last saw the deceased alive on* 11/19, 1967, *and that death occurred at* 7 PM m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 103 (Degree or title) MD

23b. ADDRESS: Bonners Ferry

23c. DATE SIGNED: 11/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/22/67

24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery

24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.: 11/29/67

REGISTRAR'S SIGNATURE: Freda Stone

25. EMBALMER: [signature]

LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 24 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 25 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4914
Local Reg. No. 55-67
Reg. Dist. No. 100

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 24 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 110 Boundary 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 110
b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
d. STREET ADDRESS (If rural, give location) P. O. Box #712

3. NAME OF DECEASED (Type or Print)
a. (First) ELMER
b. (Middle) LOT
c. (Last) HOWARD

4. DATE OF DEATH (Month) (Day) (Year) November 19, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH September 9, 1879
9. AGE (In years last birthday) 88 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Store Owner 22
10b. KIND OF BUSINESS OR INDUSTRY Retail Furniture
11. BIRTHPLACE (State or foreign country) Young County, Texas
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME David J. Howard — BIRTHPLACE Grandview, Texas
14. MOTHER'S MAIDEN NAME Sarah V. Hamilton — BIRTHPLACE Lasonia, Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 440-16-8005
17. INFORMANT'S OWN SIGNATURE Estella T. Thomas — ADDRESS Bonners Ferry Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Anemia — Terminal

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug., 1967, *to* Nov. 19, 1967, *that I last saw the deceased alive on* 11/19, 1967, *and that death occurred at* 10:15A *m., from the causes and on the date stated above.*

23a. SIGNATURE 150 (Degree or title) Frederick Dunne MD
23b. ADDRESS Bonners Ferry Idaho
23c. DATE SIGNED 11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/22/67
24c. NAME OF CEMETERY OR CREMATORY Paradise Valley Cemetery
24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. 11/21/67
REGISTRAR'S SIGNATURE Twyla Stone
25. EMBALMER Charles Malone
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Meorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4915
Local Reg. No. 57-67
Reg. Dist. No. 100

RECEIVED
NOV 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
LENGTH OF STAY (in this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): DeBoer Home, Alderson Lane 505 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 110
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
d. STREET ADDRESS (If rural, give location): Star Route #1

3. NAME OF DECEASED (Type or Print): a. (First) HORACE; b. (Middle) FRANKLIN; c. (Last) LEE

4. DATE OF DEATH: (Month) (Day) (Year): November 25, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: October 16, 1893

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Monette, Missouri

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Andrew M. Lee
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Margaret A. King
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 518-16-2252

17. INFORMANT'S OWN SIGNATURE: George L. Lee
ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): General Arteriosclerosis — Years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Ulcers — Years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, 19____, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. M. Callahan 583 (Degree or title): Coroner 4

23b. ADDRESS: Bonners Ferry, Idaho

23c. DATE SIGNED: 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/28/67

24c. NAME OF CEMETERY OR CREMATORY: Copeland Cemetery

24d. LOCATION (City, town, or county) (State): Bonners Ferry Idaho

DATE REC'D BY LOCAL REG.: 11/27/67

REGISTRAR'S SIGNATURE: Twyla Stone

25. EMBALMER:

LICENSE NO.: E-453

FIRM NAME: Hillcrest Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4916
Local Reg. No. 8
Reg. Dist. No. 670

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 120 Butte
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Howe
c. LENGTH OF STAY (in this place) Byrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mays Ranch-3 miles S. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 120 Butte
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Howe
d. STREET ADDRESS (If rural, give location) Mays Ranch-3 miles South

3. NAME OF DECEASED (Type or Print) a. (First) WALTER b. (Middle) WILLIAM c. (Last) MACKEY

4. DATE OF DEATH (Month) (Day) (Year) November 16, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH Feb. 9, 1910

9. AGE (In years last birthday) 57 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ranch Laborer 04

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Lead, So. Dakota

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Unobtainable BIRTHPLACE

14. MOTHER'S MAIDEN NAME Unobtainable BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1928-1931 3

16. SOCIAL SECURITY NO. 472-12-4128

17. INFORMANT'S OWN SIGNATURE Stanley Johnson ADDRESS Mackay, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Case Not diagnosed - Probable Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive-Attended as Coroner only *to* , 19 , *that I last saw the deceased alive on* , 19 , *and that death occurred at* 6:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE C. A. Marvel 583 (Degree or title) Butte County Coroner 4

23b. ADDRESS Arco, Idaho

23c. DATE SIGNED 11-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-22-67

24c. NAME OF CEMETERY OR CREMATORY Mt. McCaleb Cemetery

24d. LOCATION (City, town, or county) (State) Mackay, Idaho

DATE REC'D BY LOCAL REG. Dec. 1-1967

REGISTRAR'S SIGNATURE Betty J. Marvel

25. EMBALMER C. A. Marvel LICENSE NO. E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 1 1 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 3 0 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 25 1980

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PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4917
Local Reg. No. 9
Reg. Dist. No. 670

BIRTH NO.

RECEIVED DEC 5 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 120 Butte
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Arco
c. LENGTH OF STAY (in this place) mins.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 miles East 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 120 Butte
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Arco
d. STREET ADDRESS (If rural, give location) 4 Miles North

3. NAME OF DECEASED (Type or Print) a. (First) RICHARD b. (Middle) ERIC c. (Last) MOSS

4. DATE OF DEATH (Month) (Day) (Year) November 19, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH June 1, 1950
9. AGE (In years last birthday) 17 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) New London, Conn.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Irvin R. Moss BIRTHPLACE Macley, Oregon
14. MOTHER'S MAIDEN NAME Jennie Kline BIRTHPLACE Williamsburg, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Dawn Reed Moss ADDRESS Arco, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidential gunshot wound in upper right chest — INTERVAL BETWEEN ONSET AND DEATH: 30 mins.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. hemorrhage and shock

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Farm 02
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 120 (STATE) Rural-Arco Butte Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-19-67 5:30p m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? accidental discharge of shotgun

22. *I hereby certify that I attended the deceased from* 2 Attended as Coroner Only, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* 6:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE C. E. Marvel (Degree or title) 583 Butte Co. Coroner
23b. ADDRESS 4 Box # 3, Arco, Idaho
23c. DATE SIGNED 11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-22-67
24c. NAME OF CEMETERY OR CREMATORY Lost River
24d. LOCATION (City, town, or county) (State) Moore, Idaho

DATE REC'D BY LOCAL REG. Dec 1-1967
REGISTRAR'S SIGNATURE Betty J. Marvel
25. EMBALMER C. E. Marvel
LICENSE NO. E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4918
Local Reg. No. 10
Reg. Dist. No. 670

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 120 Butte 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 190
b. COUNTY: Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mackay
d. STREET ADDRESS (If rural, give location): Box 364

3. NAME OF DECEASED (Type or Print)
a. (First): ALFRED
b. (Middle): WILLIAM
c. (Last): LAMBSON

4. DATE OF DEATH (Month) (Day) (Year): November 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 2, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: Ranching
11. BIRTHPLACE (State or foreign country): Salt Lake City, Utah
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alfred B. Lambson — BIRTHPLACE: Salt Lake City, Ut.
14. MOTHER'S MAIDEN NAME: Eveline DeWitt — BIRTHPLACE: Bingham, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-18-2311
17. INFORMANT'S OWN SIGNATURE: X Don Lambson — ADDRESS: Mackay, Idaho

18. CAUSE OF DEATH 9030
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Multiple Emboli — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fracture of Femur at Trochanter — 10 days
DUE TO (c): Congestive failure

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX **SUICIDE HOMICIDE** (Specify) 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home-back porch 01/3
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 190 (STATE): Mackay Custer Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov 11-1967 6p m. 2
21e. INJURY OCCURRED 2 — WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Became dizzy after closing door and fell to floor breaking hip

22. *I hereby certify that I attended the deceased from* Nov 12, 1967, *to* Nov 25, 1967, *that I last saw the deceased alive on* Nov 25, 1967, *and that death occurred at* 4:50p *m., from the causes and on the date stated above.*

23a. SIGNATURE 031 (Degree or title): R. Barker 1
23b. ADDRESS: Arco, Idaho
23c. DATE SIGNED: 12-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 11-28-67
24c. NAME OF CEMETERY OR CREMATORY: Mt. McCaleb Cemetery
24d. LOCATION (City, town, or county) (State): Mackay, Idaho

DATE REC'D BY LOCAL REG.: Dec. 2-1967
REGISTRAR'S SIGNATURE: Betty J. Marvel
25. EMBALMER: C. H. Marvel
LICENSE NO.: E-457

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 14 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4919
Local Reg. No. 152
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 142 Canyon
b. CITY OR TOWN: Nampa
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 307 Midland Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
d. STREET ADDRESS (If rural, give location): 914 N. 9th Caldwell

3. NAME OF DECEASED (Type or Print): a. (First) Iva; b. (Middle) E.; c. (Last) Flagg

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 1, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Feb. 7, 1904

9. AGE (In years last birthday): 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Calgary, Canada

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Mac McDonald
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: No

17. INFORMANT'S OWN SIGNATURE: + Clarence S Flagg
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial Infarction
INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes Mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 66, *to* Nov 1, 19 67, *that I last saw the deceased alive on* Oct 20, 19 67, *and that death occurred at* 4 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 258 Robert H. Jensen M.D.

23b. ADDRESS: 222 EAST LOGAN

23c. DATE SIGNED: ~~MAR~~ Nov 6 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 6, 1967

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): CALDWELL, IDAHO
Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 9, 1967

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: Merville D Davis

LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4920
Local Reg. No. 149
Reg. Dist. No. 360

RECEIVED NOV 8 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1120 Albany St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Anna	M.	Olson	Nov. 1, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	July 24, 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Peter Mohr	Germany	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	519-09-2786	C. P. Olson	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial degeneration

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary sclerosis

DUE TO (c) Pregnancy complicated by hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: (a) 12 hours

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 9-14, 1967, to Nov 1, 1967, *that I last saw the deceased alive on* Nov 1, 1967, *and that death occurred at* 1 A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Caldwell Idaho	11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 6, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 6, 1967	Mrs. Martina Walmsley	Merville D Davis	E-399

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4921
Local Reg. No. 153
Reg. Dist. No. 360

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 141 Canyon 201
b. CITY OR TOWN: Caldwell | LENGTH OF STAY (in this place): 3½ weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 388 b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1111 3rd Ave. So.

3. NAME OF DECEASED (Type or Print): a. (First) Edmond b. (Middle) John 057 c. (Last) Cameron

4. DATE OF DEATH: (Month) (Day) (Year): November 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	March 2, 1891	76	–	–	–	–

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Millworker 17	Lumber	Big Timber, Montana	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John James Cameron	Oshkosh, Wisc.	Alexa Bryce	Green Bay, Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	534-10-3098	Fanny A Cameron	Payette, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2001

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lymphocytic lymphosarcoma, lung. — INTERVAL BETWEEN ONSET AND DEATH: 22 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart disease
DUE TO (c) pulmonary emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-18-67	(above)	YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
–	–	–

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
– m.		–

22. *I hereby certify that I attended the deceased from* 10-12- *1967, to* 11-2- *1967, that I last saw the deceased alive on* 11-2- *1967, and that death occurred at* 9:30A. *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
J M Salrang 425 (Degree or title) M.D.	Caldwell, Idaho	11-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-burial	11/7/67	Council Cemetery	Council Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 9, 1967	Mrs. Martina Walmsley	Keith M Jensen	E-517

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4922
Local Reg. No. 151
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 124 E. Logan St.

3. NAME OF DECEASED (Type or Print)
a. (First) Love
b. (Middle) Miller
c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) Nov. 2, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 20, 1875
9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Panora, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Benjamin F. Miller — BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Matilda Replogle — BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-0005A
17. INFORMANT'S OWN SIGNATURE [signature] — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Severe arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: gradual several yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cerebrovascular occlusions — 4 years
Senile dementia — 3 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1956, to 11-2, 1967, that I last saw the deceased alive on 11-2, 1967, and that death occurred at 2 P m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 280 (Degree or title) MD 1
23b. ADDRESS 1819 Ellis St Caldwell Idaho
23c. DATE SIGNED 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery
24d. LOCATION (City, town, or county) (State) Nampa, Idaho

DATE REC'D BY LOCAL REG. Nov. 9, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Merville D. Davis
LICENSE NO. E-399

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 20 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4923
Local Reg. No. 169
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN Nampa
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 301 Midland Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 816 14th. Ave. So. Nampa

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	JAMES	I.	LIBBY	11	3	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	White	Single	3/ 20/ 1891	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. R. R.	Railroad	Pratt County, Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles O. Libby	Maine	Mary Robinson	Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-30-5932	Maxine Webster	Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Ischemia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Aortic Stenosis; Chronic Fibrous Pericarditis, Chronic Myocarditis — 10+ yrs

DUE TO (c) Atherosclerosis - Cardio Vascular Progressive — 10+ yrs — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerosis - generalized — 20 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb, 19 58, *to* 3 Nov, 19 67, *that I last saw the deceased alive on* Nov. 3, 19 67, *and that death occurred at* 1:10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
443 C R Riordan	MD	Nampa Idaho	15 Nov 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/6/ 67	Kohlerlawn Cemetery	Nampa, Canyon Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 17, 1967	Mrs. Martina Walmsley	Boyce Sinclair	E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 4924
Local Reg. No. 171
Reg. Dist. No. 360

BIRTH NO.

NOV 20 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 145 CANYON 316
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
c. LENGTH OF STAY (in this place) 16 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 142 CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 1616 GARRITY BLVD.

3. NAME OF DECEASED (Type or Print) a. (First) DELPHA b. (Middle) c. (Last) SLOAN

4. DATE OF DEATH (Month) (Day) (Year) NOV. 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	DIVORCED 4	OCT. 17, 1913	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NURSES AID 13	IDA. STATE HOSP.	EMMETT, IDAHO	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
LEE STEINBACH	MISSOURI	DAISY HEATH	MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	519-18-8644	X John L. Sloan	TOMS RIVER, NEW JERSEY

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 180X Carcinoma of Kidney with Generalized Metastasis — INTERVAL BETWEEN ONSET AND DEATH 3 months.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 12-27- *,* 19 65 *, to* 11-4- *,* 19 67 *, that I last saw the deceased alive on* 11-4- *,* 19 67 *, and that death occurred at* 9:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Richard C. Jungen 666 M.D.	NAMPA, IDAHO	11-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	11-8-67	MERIDIAN CEMETERY	MERIDIAN, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 17, 1967	Mrs. Martina Walmsley	M. B. Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4925
Local Reg. No. 161
Reg. Dist. No. 360

RECEIVED
NOV 15 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 010
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Star
d. STREET ADDRESS (If rural, give location) P. O. Box #132

3. NAME OF DECEASED (Type or Print)
a. (First) Sarah
b. (Middle) Delana
c. (Last) Zabel

4. DATE OF DEATH (Month) (Day) (Year) November 4, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 23, 1884
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home making
11. BIRTHPLACE (State or foreign country) Lehigh, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lee Crouse — BIRTHPLACE Iowa
14. MOTHER'S MAIDEN NAME Sarah Bates — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-60-4010T
17. INFORMANT'S OWN SIGNATURE Kathryn T. Schmith — ADDRESS Caldwell

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11-62, 19__, *to* 11-4-67, 19__, *that I last saw the deceased alive on* 11-4-67, 19__, *and that death occurred at* 9:25A. *m., from the causes and on the date stated above.*

23a. SIGNATURE W Hufler MD 250 (Degree or title)
23b. ADDRESS 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED 11-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Star Cemetery
24d. LOCATION (City, town, or county) Ada County (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 14, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Don W. Singham — LICENSE NO. E-496
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and, if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4926
Local Reg. No. 158
Reg. Dist. No. 360

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) 324 Denver

3. NAME OF DECEASED (Type or Print) a. (First) CLARENCE b. (Middle) M 051 c. (Last) EVERHART

4. DATE OF DEATH (Month) 11 (Day) 5 (Year) 67

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH June 10, 1897

9. AGE (In years last birthday) 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Jailer 08

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Emmett, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas J. Everhart BIRTHPLACE Kirksville, Mo.

14. MOTHER'S MAIDEN NAME Minnie Bercher BIRTHPLACE Peoria, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Two 4

16. SOCIAL SECURITY NO. 519-12-7152

17. INFORMANT'S OWN SIGNATURE Clarence E. Everhart ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer Lung 1637 — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July *1967, to* Nov *, 1967, that I last saw the deceased alive on* Nov 5 *, 1967, and that death occurred at* 4:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 437 MD
23b. ADDRESS Caldwell Idaho
23c. DATE SIGNED 11/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/9/67
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 13, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Leonard C. Flahiff
LICENSE NO. E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4927
Local Reg. No. 160
Reg. Dist. No. 360

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 142 CANYON 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
c. LENGTH OF STAY (In this place) 10 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 215 CHESTNUT 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY 142 CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 215 CHESTNUT

3. NAME OF DECEASED (Type or Print) a. (First) LURA b. (Middle) K. c. (Last) FITZ

4. DATE OF DEATH (Month) (Day) (Year) NOV. 6, 1967

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3

8. DATE OF BIRTH NOV. 14, 1891

9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE 01

10b. KIND OF BUSINESS OR INDUSTRY AT HOME

11. BIRTHPLACE (State or foreign country) JOY TEXAS

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME CHARLES T. WITTEN — BIRTHPLACE VIRGINIA

14. MOTHER'S MAIDEN NAME ELIZABETH K. STAGG — BIRTHPLACE TEXAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 574-05-1438A

17. INFORMANT'S (OWN) SIGNATURE R G Fitz — ADDRESS NAMPA, IDAHO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's disease - osteoarthritis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-6, 1967, *to* 11-6, 1967, *that I last saw the deceased alive on* 11-2, 1967, *and that death occurred at* 3:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE Henry C Wesche 560 (Degree or title) M.D

23b. ADDRESS NAMPA, IDAHO

23c. DATE SIGNED 11-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 11-9-67

24c. NAME OF CEMETERY OR CREMATORY KOHLER LAWN CEMETERY

24d. LOCATION (City, town, or county) (State) NAMPA, IDAHO

DATE REC'D BY LOCAL REG. Nov. 13, 1967

REGISTRAR'S SIGNATURE Mrs Martina Walmsley

25. EMBALMER M. B. Shepherd

LICENSE NO. 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4928
Local Reg. No. 154
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
NOV 13 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa Rural
d. STREET ADDRESS (If rural, give location): Rt. 6

3. NAME OF DECEASED (Type or Print)
a. (First): Cora
b. (Middle): H.
c. (Last): Pritchett

4. DATE OF DEATH (Month) (Day) (Year): Nov. 6, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 27, 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Hampton, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank C. Heise — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Amelia Mueller — BIRTHPLACE: Ukn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Donald V. Pritchett — ADDRESS: Rt. 6 Nampa

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

465X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Embolis rt.

ANTECEDENT CAUSES — Source not determined

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Sarcoma, retroperitoneal, pelvic

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Autopsy only, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 1:30A. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 147 Ed Brouillard mrs. 1
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 11-9-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Nov. 10, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Geo. Jerread
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4929
Local Reg. No. 164
Reg. Dist. No. 360

RECEIVED
NOV 16 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN Caldwell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION I.O.O.F. Home 195

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 401 b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Andrew b. (Middle) c. (Last) Larsen
4. DATE OF DEATH (Month) (Day) (Year) November 6, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Aug. 24, 1887
9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Smelterman
10b. KIND OF BUSINESS OR INDUSTRY 07 Mining
11. BIRTHPLACE (State or foreign country) Denmark
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lawrits Larsen
BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 506-16-9970
17. INFORMANT'S OWN SIGNATURE Lawrits Larsen
ADDRESS Kellogg, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA — INTERVAL BETWEEN ONSET AND DEATH 10 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) diabete — 5 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 5 *1967, to* Nov 6 *, 1967, that I last saw the deceased alive on* Nov 5 *, 1967, and that death occurred at* 3:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE Ted E Reynolds 437 (Degree or title) MD
23b. ADDRESS Caldwell Idaho
23c. DATE SIGNED 11/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 15, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Rodney A. Dakan
LICENSE NO. IE-605
FIRM NAME: Peckham Dakan Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16, inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 5 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4930
Local Reg. No. 163
Reg. Dist. No. 360

RECEIVED
NOV 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 140 Canyon 152
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Parma
c. LENGTH OF STAY (in this place) 52yr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) RFD 2 Parma 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 140
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Parma
d. STREET ADDRESS (If rural, give location) RFD 2 Parma

3. NAME OF DECEASED (Type or Print)
a. (First) William
b. (Middle) Sherman
c. (Last) Wilson

4. DATE OF DEATH (Month) (Day) (Year) 11-7-1967

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 10-28-1908
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John A Wilson — BIRTHPLACE Tennessee
14. MOTHER'S MAIDEN NAME Mary Lenis — BIRTHPLACE Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-10-1497
17. INFORMANT'S OWN SIGNATURE X Helen L. Wilson — ADDRESS RFD 2 PARMA IDAHO

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — many years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11, 1961, *to* 11-7, 1967, *that I last saw the deceased alive on* 11-6, 1967, *and that death occurred at* 11:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 324 [signature] M.D.
23b. ADDRESS Arlington, Oregon
23c. DATE SIGNED 11-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-10-1967
24c. NAME OF CEMETERY OR CREMATORY Parma
24d. LOCATION (City, town, or county) Parma (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 14, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. FUNERAL DIRECTOR [signature]
ADDRESS Nyssa Oregon

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

NOV 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

.....

Certificate of Death

STATE OF IDAHO

State File No. 4931
Local Reg. No. 168
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 17 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 140 Canyon 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Parma
c. LENGTH OF STAY (In this place) 6 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Myer's Ranch Home, Rt. 1

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 6413 Randolph Drive

3. NAME OF DECEASED (Type or Print)
a. (First) ETHEL
b. (Middle) G.
c. (Last) TYLER

4. DATE OF DEATH (Month) (Day) (Year) November 7, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Oct. 26, 1891

9. AGE (In years last birthday) 76
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife

10b. KIND OF BUSINESS OR INDUSTRY retired

11. BIRTHPLACE (State or foreign country) Minor County, South Dakota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John G. Gray
BIRTHPLACE South Dakota

14. MOTHER'S MAIDEN NAME Grace Linder
BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 518-07-0152

17. INFORMANT'S OWN SIGNATURE 6413 Randolph Drive
ADDRESS Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Apparent Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardiovascular — about 3 years
DUE TO (c) disease - with dementia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ---, 19--, *to* ---, 19--, *that I last saw the deceased alive on* ---, 19--, *and that death occurred at* 8:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Charles C. Kemish (Degree or title) M.D.

23b. ADDRESS 1819 Ellis St Caldwell Idaho

23c. DATE SIGNED 11-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 10 '67

24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State) Boise, Route 2, Idaho

DATE REC'D BY LOCAL REG. Nov. 16, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER J. Richard Reed

LICENSE NO. E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 27 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 20 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 23 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 13 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician: This patient was a senile dementia with arteriosclerosis & had resided at Myra Nursing home at Parma for some three years. She has not had a recent medical attendant & has not appeared to need one. She passed away suddenly without warning.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 16 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4932
Local Reg. No. 162
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 147 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blakley's Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 147 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 1704 Dearborn St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Myrtle	E.	Pease	Nov. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Nov. 8, 1885	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Maquoketa, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eli Edwards	Iowa	Gee	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Mrs. J. H. Gipson, Jr.	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: consistent

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) advanced arteriosclerosis — several months
DUE TO (c) Cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov. , 1966, *to* 11-7 , 1967, *that I last saw the deceased alive on* 10-27 , 1967, *and that death occurred at* 6:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles Kennedy 280	MD	1819 Ellis St Caldwell Idaho	11-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 9, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 14, 1967	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4933
Local Reg. No. 159
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 14 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 CANYON 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA | LENGTH OF STAY (In this place) 3MO.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MIDLAND MANOR 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 142 COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 616 11th AVE. SOUTH

3. NAME OF DECEASED (Type or Print): a. (First) EDWYNA b. (Middle) G. c. (Last) PERRY

4. DATE OF DEATH (Month) (Day) (Year): NOV. 8, 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2

8. DATE OF BIRTH: APRIL 28, 1883

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 84

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME MAKER 01

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): ELKADOR, IOWA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: EDMOND GIFFORD | BIRTHPLACE: IOWA

14. MOTHER'S MAIDEN NAME: MARY MUNZER | BIRTHPLACE: PENN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 568-52-8522

17. INFORMANT'S OWN SIGNATURE: X Dr. E. M. Perry | ADDRESS: NAMPA, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebro Vasc Thrombosis — 2mo

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* Nov, 19 67, *that I last saw the deceased alive on* 9 Nov, 19 67, *and that death occurred at* 8:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE 326 (Degree or title) M. D. — **23b. ADDRESS**: NAMPA, IDAHO — **23c. DATE SIGNED**: 11-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3 — **24b. DATE**: 11-10-67 — **24c. NAME OF CEMETERY OR CREMATORY**: OAKWOOD CEMETERY — **24d. LOCATION** (City, town, or county) (State): AUSTIN, MINNESOTA

DATE REC'D BY LOCAL REG.: Nov. 13, 1967 — **REGISTRAR'S SIGNATURE**: Mrs. Martina Walmsley — **25. EMBALMER**: M. B. Shepherd — **LICENSE NO.**: 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4934
Local Reg. No. 178
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. Mercy Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 142 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 315-13 Avenue South

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) C. c. (Last) Blodgett
4. DATE OF DEATH (Month) (Day) (Year) November 8, 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH December 3, 1881
9. AGE (In years last birthday) 85 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Litchfield Nebraska
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Cornellius Blodgett BIRTHPLACE Michigan
14. MOTHER'S MAIDEN NAME Susan Hooley BIRTHPLACE Indiana
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 508 01 5583
17. INFORMANT'S OWN SIGNATURE x Ora B Blodgett ADDRESS Nampa, Ida. 315-13Ave. So.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4200 Arteriosclerotic Heart — INTERVAL BETWEEN ONSET AND DEATH 1 wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Decrease in Systolic Failure
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* approx. Nov 6 19 67 *to* Nov 8, 19 67, *that I last saw the deceased alive on* Nov 8, 19 67, *and that death occurred at* 8:00P. m., *from the causes and on the date stated above.*

23a. SIGNATURE 322 (Degree or title)
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 11/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 27, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER
LICENSE NO. E-496
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 28 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 30 1979

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4935
Local Reg. No. 170
Reg. Dist. No. 360

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 252 High Street

3. NAME OF DECEASED (Type or Print) a. (First) EFFIE b. (Middle) REBEKAH c. (Last) ALLEN

4. DATE OF DEATH (Month) (Day) (Year) November 8, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 12, 1884
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Montpelier, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alfred W. Smith BIRTHPLACE Ireland
14. MOTHER'S MAIDEN NAME Ellen Reece BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 24 7002D
17. INFORMANT'S OWN SIGNATURE ADDRESS × Sidney D. Allen Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion
(b) Myocardial Infarction
DUE TO (b)
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-6- *19* 62, *to* 11-8- *19* 67, *that I last saw the deceased alive on* 11-8- *19* 67, *and that death occurred at* 8:45P. *m., from the causes and on the date stated above.*

23a. SIGNATURE 454 (Degree or Title)
23b. ADDRESS 619 So. Canyon, Nampa, Idaho
23c. DATE SIGNED 11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 17, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER
LICENSE NO. E-496
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 14 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4936
Local Reg. No. 172
Reg. Dist. No. 360

RECEIVED
NOV 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141 000
b. CITY OR TOWN Caldwell (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 140 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Notus
d. STREET ADDRESS (If rural, give location) Box 155

3. NAME OF DECEASED (Type or Print) a. (First) Emmett b. (Middle) E. c. (Last) Park
4. DATE OF DEATH (Month) (Day) (Year) Nov. 9, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 28, 1892
9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Indiana Territory, Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George B. Park BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Genevia S. McKinley BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-10-6616
17. INFORMANT'S OWN SIGNATURE Grant E. Park ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer terminal Bladder — INTERVAL BETWEEN ONSET AND DEATH 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Cystitis Pyelonephritis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 11-7-67
19b. MAJOR FINDINGS OF OPERATION Bilateral inguinal hernea - Pyelonephrosis
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10-26, 1967, to 11-9, 1967, that I last saw the deceased alive on 11-9, 1967, and that death occurred at 5 A m., from the causes and on the date stated above.

23a. SIGNATURE Grant E. Park, M.D. (Degree or title)
23b. ADDRESS Caldwell Idaho
23c. DATE SIGNED 11-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 20, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Merville D. Davis
LICENSE NO. E-399
FIRM NAME: Peckham-Dakan Funeral Chapel, Caldwell

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1967

AUG 8 1968

JAN 16 1973

JUN 29 1981

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4937
Local Reg. No. 165
Reg. Dist. No. 360

RECEIVED
NOV 17 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 CANYON 204
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
c. LENGTH OF STAY (in this place) 4 MO.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MIDLAND MANOR 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 142
b. COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 816 6th STREET NORTH

3. NAME OF DECEASED (Type or Print)
a. (First) ESTHER
b. (Middle) M.
c. (Last) MASON

4. DATE OF DEATH (Month) (Day) (Year) NOV. 9, 1967

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) MARRIED 3
8. DATE OF BIRTH JAN. 1, 1888
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE 01
10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (State or foreign country) MANDON, NORTH DAKOTA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME NO RECORD VETZ — BIRTHPLACE GERMANY
14. MOTHER'S MAIDEN NAME ELIZABETH NO RECORD — BIRTHPLACE NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 469-12-5691A
17. INFORMANT'S OWN SIGNATURE C. Glenn Mason — ADDRESS NAMPA, IDAHO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

151X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis, generalized — INTERVAL BETWEEN ONSET AND DEATH: Approx.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Carcinoma of stomach — 2 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION 8-11-66
19b. MAJOR FINDINGS OF OPERATION Carcinoma of stomach
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 10, 1966, *to* Nov. 9, 1967, *that I last saw the deceased alive on* Oct. 28, 1967, *and that death occurred at* 5:25 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert H. Blome, MD 048 (Degree or title)
23b. ADDRESS NAMPA, IDAHO
23c. DATE SIGNED 11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 11-16-67
24c. NAME OF CEMETERY OR CREMATORY KOHLERLAWN CEMETERY
24d. LOCATION (City, town, or county) (State) NAMPA, IDAHO

DATE REC'D BY LOCAL REG. Nov. 16, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER M. B. Shepherd — LICENSE NO. 473
FIRM NAME SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4938
Local Reg. No. 166
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 17 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 14 CANYON 30
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) CALDWELL
LENGTH OF STAY (in this place) 10 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) CALDWELL MEMORIAL HOSPITAL 031

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 16
b. COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL NAMPA
d. STREET ADDRESS (If rural, give location) RT. 3

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	FREDDIE	G.	RAND	NOV.	9,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
MALE	WHITE	NEVER MARRIED	OCT. 9, 1946	21				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
SALESMAN 24	INSURANCE	GUTHERIE, OKLAHOMA	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
GIL R. RAND	OREGON	BEATRICE M. McKINLEY	TEXAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		543-50-0621	[signature]	NAMPA, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Transection of spinal chord at C6 — INTERVAL BETWEEN ONSET AND DEATH: 13 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) pneumonia
DUE TO (c) bleeding gastric ulcers

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bilateral hemppneumothorax

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-28-67	Ruptured liver and spleen and fracture C-6.	YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
auto	highway 06	13		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
10-28-67 m.	WHILE AT WORK [ ] NOT WHILE AT WORK [X]	

22. *I hereby certify that I attended the deceased from* 10-28-67, 19 67, *to* 11-9-67, 19 67, *that I last saw the deceased alive on* 11-9-67, 19 67, *and that death occurred at* 7:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A M Salmons 425	MD	CALDWELL, IDAHO	11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	11-15-67	HILLCREST MEMORIAL	CANYON COUNTY, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 16, 1967	Mrs. Martina Walmsley	M. B. Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4939
Local Reg. No. 167
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
NOV 17 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 11/ Canyon 001
b. CITY OR TOWN: Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 370 Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Marsing
d. STREET ADDRESS (If rural, give location): Box 223

3. NAME OF DECEASED (Type or Print)
a. (First): Fred
b. (Middle): C.
c. (Last): Reich

4. DATE OF DEATH (Month) (Day) (Year): Nov. 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 7, 1885

9. AGE (In years last birthday): 82
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kassel, South Russia

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Christian Reich
BIRTHPLACE: Russia

14. MOTHER'S MAIDEN NAME: Fredrica Lang
BIRTHPLACE: Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-10-0700

17. INFORMANT'S OWN SIGNATURE: Alvin Reich
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 260X Coronary Occlusion — Interval between onset and death: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Coronary Sclerosis — Interval between onset and death: 8 yrs

DUE TO (c): Diabetes mellitus — Interval between onset and death: 8 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 10, 1967, *to* Nov 8, 1967, *that I last saw the deceased alive on* Nov 8, 1967, *and that death occurred at* 5:20 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD

23b. ADDRESS: Caldwell Ida

23c. DATE SIGNED: 11-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 13, 1967

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Nov. 16, 1967

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: Neville D. Davis

LICENSE NO.: E-399

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 3 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4940
Local Reg. No. 176
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 24 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place) 1 day 301
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) 321 Aven St.

3. NAME OF DECEASED (Type or Print)
a. (First) Ida
b. (Middle) M.. 051
c. (Last) Kerr

4. DATE OF DEATH (Month) (Day) (Year) Nov. 10, 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Aug. 23, 1897
9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR Months 2 Days 17 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Enid Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joe Ab Mitchell — BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Isabell Crawford — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 568-26-5427A
17. INFORMANT'S OWN SIGNATURE x H. Clifford Troop — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion I

ANTECEDENT CAUSES — Myocardial ischemia

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary sclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-9, 1967, *to* 11-10, 1967, *that I last saw the deceased alive on* 11-10, 1967, *and that death occurred at* 24 *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 166 (Degree or title)
23b. ADDRESS Caldwell Idaho
23c. DATE SIGNED 11-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Removal
24b. DATE Nov 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Mt. View
24d. LOCATION (City, town, or county) Ashland, (State) Oregon

DATE REC'D BY LOCAL REG. Nov. 22, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Leonard C. Flahiff
LICENSE NO. E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4941
Local Reg. No. 173
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN: Caldwell | LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION: Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 141 b. COUNTY: Canyon
c. CITY OR TOWN: Caldwell
d. STREET ADDRESS (If rural, give location): Rt. # 3

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Irma	M.	Pecich	Nov. 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Oct. 4, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Muelebecka, Belgium
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Henry Van Derviaene — BIRTHPLACE: Belgium
14. MOTHER'S MAIDEN NAME: Marie — BIRTHPLACE: Belguim

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: No
17. INFORMANT'S OWN SIGNATURE: R. Marion Viane — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left cerebral artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis
DUE TO (c) hypertension

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. diabetes

332X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-24, 1967, *to* 11-13, 1967, *that I last saw the deceased alive on* 11-13, 1967, *and that death occurred at* 10P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 166
23b. ADDRESS: Caldwell, Ida.
23c. DATE SIGNED: 11-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Ten Davis Cemetery
24d. LOCATION (City, town, or county) (State): Parma, Idaho

DATE REC'D BY LOCAL REG.: Nov. 21, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Melville D Davis
LICENSE NO.: E-399
FIRM NAME: Peckham-Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4942
Local Reg. No. 190
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middleton
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Eva		Eberle	Nov. 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Oct. 20, 1892	75				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		McTosh, North Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Carl Hager	Romania	Christina	Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-60-4001 T	Christina E Eberle	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Pneumonia	3d
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	CVA	4wks
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Congestive Heart Failure	3mo

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct, 1967, *to* Nov, 1967, *that I last saw the deceased alive on* Nov 10, 1967, *and that death occurred at* 9 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul E Reynolds MD	Caldwell Idaho	11/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 17, 1967	Hillcrest Memorial Garden	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 4, 1967	Mrs Martha Walmsley	Marvella D. Davis	E-399

FIRM NAME: Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form PH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

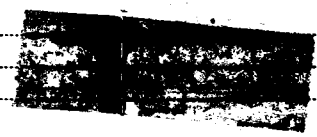

Certificate of Death

STATE OF IDAHO

State File No. 4943
Local Reg. No. 175
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 24 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 141 Canyon 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 140 b. COUNTY Canyon

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parma

d. STREET ADDRESS (If rural, give location) Rt. # 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Orvil	Franklin	Smyser	Nov. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Jan. 19, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 04		Glenwood, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Samuel Smyser	Missouri	Sadie Terry	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Sam Smyser	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Diabetes mellitus

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1965 19 *to* 11/15, 1967, *that I last saw the deceased alive on* 11/14, 1967, *and that death occurred at* 2:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald C. Bauman 034	M.D.	Caldwell, Idaho	11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 17, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	EMBALMER	LICENSE NO.
Nov. 22, 1967	Mrs. Martina Walmsley	Merville D Davis	E-399

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Peckham-Dakan Chapel, Caldwell, Idaho

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 23 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4944
Local Reg. No. 177
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 24 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 140
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1½ mi. East of Homedale

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 370
b. COUNTY: Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
d. STREET ADDRESS (If rural, give location): City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Nancy	E.	Bertrand	Nov. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	June 3, 1901	66	5	12		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Self	Jackson County, Alabama	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Pitts Oldham	Missouri	Sara Presley	Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		442-05-6677	x Roberta Greer	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Sclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* June 1, 19 5x, *to* Nov 15, 1967, *that I last saw the deceased alive on* Nov 1, 1967, *and that death occurred at* 9 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
570 MD	Caldwell Ida	11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 20, 1967	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 22, 1967	Mrs. Martina Walmsley	Leonard C. Flaniff	E-481

FIRM NAME: Homedale's Flaniff Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4945
Local Reg. No. 179
Reg. Dist. No. 360

RECEIVED NOV 28 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO. 302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: CANYON
b. CITY OR TOWN (If outside corporate limits write RURAL and give township): CALDWELL
c. LENGTH OF STAY IN (this place): 2 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION: CALDWELL MEMORIAL HSOPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 2227 SPALDING

3. NAME OF DECEASED (Type or Print): a. (First) ETHEL b. (Middle) A. c. (Last) OLSEN

4. DATE OF DEATH (Month) (Day) (Year): NOV. 15 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2

8. DATE OF BIRTH: MAY 19, 1885

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 82

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME-MAKER 01

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): UTAH

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: HANS C. BONNERU — BIRTHPLACE: NORWAY

14. MOTHER'S MAIDEN NAME: BRIGHAMINA OLSEN — BIRTHPLACE: SWEDEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 579-24-6036

17. INFORMANT'S OWN SIGNATURE: x Flora Jones — ADDRESS: NAMPA, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-14-67, 19___, *to* 11-15-67, 19___, *that I last saw the deceased alive on* 11-15-67, 19___, *and that death occurred at* 7:45 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 178 MD 1

23b. ADDRESS: CALDWELL, IDAHO

23c. DATE SIGNED: 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

24b. DATE: 11-20-67

24c. NAME OF CEMETERY OR CREMATORY: KOHLER LAWN CEMETERY

24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Nov. 27, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: W. B. Shepherd

LICENSE NO.: 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED NOV 29 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 4946
Local Reg. No. 182
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 142 Canyon 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 3 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 016
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kuna
d. STREET ADDRESS (If rural, give location): 501 Ash

3. NAME OF DECEASED (Type or Print): a. (First) Carrie b. (Middle) L. c. (Last) Doan

4. DATE OF DEATH (Month) (Day) (Year): Nov. 15, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: Aug. 4, 1910

9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oklahoma

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: David L. Doan — BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Nettie B. Hunt — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: David Lee Doan — ADDRESS: Kuna

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Rheumatic Heart Disease + Decompensation — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Thrombosis Rt. Hemoplegia — 2 wks

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3-11- 1966, *to* 11-15-, 1967, *that I last saw the deceased alive on* 11-14-, 1967, *and that death occurred at* 4:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Gerald E Wenke 559 (Degree or title) MD

23b. ADDRESS: Nampa Ida

23c. DATE SIGNED: 11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-18-67

24c. NAME OF CEMETERY OR CREMATORY: Kuna Cemetery

24d. LOCATION (City, town, or county) (State): Kuna, Idaho

DATE REC'D BY LOCAL REG.: Nov. 28, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Geo Jerred — LICENSE NO.: E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

NOV 28 1967

Bureau of Vital Statistics

State File No. 4947
Local Reg. No. 180
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 42 Canyon 000
b. CITY OR TOWN Nampa
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 315-7th Ave. So.

3. NAME OF DECEASED (Type or Print)
a. (First) Rev. Robert
b. (Middle) Gilbert
c. (Last) Hammond

4. DATE OF DEATH (Month) (Day) (Year) Nov. 16, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Sept. 6, 1885

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Minister 18

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) San Francisco, California

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Otis Hammond
BIRTHPLACE California

14. MOTHER'S MAIDEN NAME Alice Bibbons
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 554-20-7388

17. INFORMANT'S OWN SIGNATURE x Mrs Robert Hammond
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hodgkins Disease — INTERVAL BETWEEN ONSET AND DEATH 9 years.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-26-66, *to* 11-16-1967, *that I last saw the deceased alive on* 11-16-67, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Richard C. Troyer (Degree or title) 666 M.D.

23b. ADDRESS Richard C. Troyer, M.D., 619 So. Canyon

23c. DATE SIGNED 11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 20, 1967

24c. NAME OF CEMETERY OR CREMATORY Hillcrest Mem. Garden

24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Nov. 27, 1967

REGISTRAR'S SIGNATURE Mrs. Martin Walmsley

25. EMBALMER Rodney W. Dakan

LICENSE NO. E-608

FIRM NAME: Peckham-Dakan Chapel, Caldwell

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4948
Local Reg. No. 174
Reg. Dist. No. 360

BIRTH NO.

RECEIVED NOV 24 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 140 Canyon 205

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nampa

c. LENGTH OF STAY (in this place) 5mo

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boulevard Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE 38 Oregon

b. COUNTY 355 Malheur

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Nyssa

d. STREET ADDRESS (If rural, give location) RFD 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Walter	Allen	Fox	11-17-1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
M	W	Married 3	2-16-1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 84	Farm	Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George E Fox	Iowa	Arilla Berry	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		x Sylvia Fox	RFD 2 Nyssa Oregon

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 7-19, 1967, *to* 11-17, 1967, *that I last saw the deceased alive on* 11-15, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry C Wesche MD 560	Nampa Idaho	11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-20-1967	Nyssa	Nyssa Oregon

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
Nov. 22, 1967	Mrs. Martina Walmsley	Richard W. Meservy Embalmer	E-487

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

.....

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State File No. 4949
Local Reg. No. 192
Reg. Dist. No. 360

Certificate of Death

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place) 5 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 13 Idaho
b. COUNTY 140 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wilder
d. STREET ADDRESS (If rural, give location) Box 536

3. NAME OF DECEASED (Type or Print)
a. (First) George
b. (Middle) Lewis 051
c. (Last) Fuller

4. DATE OF DEATH (Month) (Day) (Year) Nov. 19, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH June 9, 1900
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR Months 5 Days 10 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) theater operator
10b. KIND OF BUSINESS OR INDUSTRY 23 entertainment
11. BIRTHPLACE (State or foreign country) Emmett, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Gwynn Fuller — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Emma Laing — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-0701706A
17. INFORMANT'S OWN SIGNATURE X Edna L. Fuller — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 151X Carcinoma of Stomach — INTERVAL BETWEEN ONSET AND DEATH 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-3-53, 19__, *to* 11-19-67, 19__, *that I last saw the deceased alive on* 11-19-67, 19__, *and that death occurred at* 2:15A. *m., from the causes and on the date stated above.*

23a. SIGNATURE W. Nuckolls 250 (Degree or title)
23b. ADDRESS 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED 11-24-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Nov. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY Emmett
24d. LOCATION (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. Dec. 4, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Walter Potter
LICENSE NO. E445

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: THE BEATTY CHAPEL Emmett, Id

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4950
Local Reg. No. 185
Reg. Dist. No. 360

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 30 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 141 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
d. STREET ADDRESS (If rural, give location) Rt. # 1

3. NAME OF DECEASED (Type or Print)
a. (First) Vernum
b. (Middle) A.
c. (Last) Bailey

4. DATE OF DEATH (Month) (Day) (Year) Nov. 20, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 23, 1878
9. AGE (In years last birthday) 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Grantsville, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Bailey — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Mary Barett — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE C D Bailey — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

465X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Renal Failure — INTERVAL BETWEEN ONSET AND DEATH 48 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Pulmonary embolism — 72 hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Pneumonia — 18 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2 Nov, 1967, *to* 20 Nov, 1967, *that I last saw the deceased alive on* 20 Nov, 1967, *and that death occurred at* 9:55 P m., *from the causes and on the date stated above.*

23a. SIGNATURE A L Poulsen M.D. 651 (Degree or title)
23b. ADDRESS Caldwell Idaho
23c. DATE SIGNED 27 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY Middleton Cemetery
24d. LOCATION (City, town, or county) (State) Middleton, Idaho

DATE REC'D BY LOCAL REG. Nov. 29, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Kenneth E Spence
LICENSE NO. E-395

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4951
Local Reg. No. 184
Reg. Dist. No. 360

BIRTH NO.

RECEIVED

NOV 30 1967

Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN: Caldwell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: Home, 910 Main St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN: Caldwell
d. STREET ADDRESS (If rural, give location): 910 Main St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Maysel	Cooper	McInturff	Nov. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed 2	April 26, 1886	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Caldwell, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: C. W. Cooper — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Dora Dering — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-46-7486A
17. INFORMANT'S OWN SIGNATURE: Vera Mason — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): ASHD — 10 yrs

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

4201

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1967, *to* Nov, 1967, *that I last saw the deceased alive on* Nov 27, 1967, *and that death occurred at* 2:30 p.m. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert H. Jensen, M.D. 258
23b. ADDRESS: 222 EAST LOGAN CALDWELL IDAHO
23c. DATE SIGNED: 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 27, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
(Location) (City, town, or county): Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG.: Nov. 29, 1967
REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley
25. EMBALMER: Merville D Davis
LICENSE NO.: E-399

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-10817
BIRTH NO.

Certificate of Death

RECEIVED
DEC 5 1967
Bureau of Vital Statistics
STATE OF IDAHO

State File No. 4952
Local Reg. No. 187
Reg. Dist. No. 360

1. PLACE OF DEATH
a. COUNTY 142 CANYON 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 142 b. COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 372 Caldwell Blvd.

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) Duane c. (Last) Frickey

4. DATE OF DEATH (Month) (Day) (Year) Nov. 20, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant 7

8. DATE OF BIRTH November 18, 1967

9. AGE (In years last birthday) 0 | IF UNDER 1 YEAR Months 0 Days 2 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02

10b. KIND OF BUSINESS OR INDUSTRY ---

11. BIRTHPLACE (State or foreign country) Nampa, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Mark L. Frickey BIRTHPLACE Washington

14. MOTHER'S MAIDEN NAME Judy Canning BIRTHPLACE Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Mark L. Frickey ADDRESS Nampa

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

752 X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hydrocephalus — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) X-linked recessive inheritance
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-18-, 1967, *to* 11-20, 1967, *that I last saw the deceased alive on* 11-20, 1967, *and that death occurred at* 11:40A m., *from the causes and on the date stated above.*

23a. SIGNATURE 3446 (Degree or title) **23b. ADDRESS** 619 So Canyon **23c. DATE SIGNED** Nov 24, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial **24b. DATE** Nov. 22, 1967 **24c. NAME OF CEMETERY OR CREMATORY** Hillcrest Gardens **24d. LOCATION** (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 1, 1967 **REGISTRAR'S SIGNATURE** Mrs. Martina Walmsley

25. EMBALMER Richard W. Meagher **LICENSE NO.** E-481

FIRM NAME Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4953
Local Reg. No. 181
Reg. Dist. No. 360

Certificate of Death

RECEIVED
NOV 29 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 527 Fairview

3. NAME OF DECEASED (Type or Print)
a. (First) Anna
b. (Middle) Justina
c. (Last) Marsh

4. DATE OF DEATH (Month) (Day) (Year) Nov. 21, 1967

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH February 28, 1894
9. AGE (In years last birthday) 73 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Glendale Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Wendelin Schey — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Clara Michel — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-32-2973A
17. INFORMANT'S OWN SIGNATURE ✓ Elizabeth S. Grisham — ADDRESS Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

170X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Septicemia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of breast
DUE TO (c) Met to bone

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Inner

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 9/9/65
19b. MAJOR FINDINGS OF OPERATION Rad. mastectomy
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/9, 1965, *to* 11/2, 1967, *that I last saw the deceased alive on* 11/2, 1967, *and that death occurred at* 7:30P. *m., from the causes and on the date stated above.*

23a. SIGNATURE S. C. Tazz, MD 524 (Degree or title)
23b. ADDRESS 619 Canyon Nampa
23c. DATE SIGNED 11/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
24d. LOCATION (City, town, or county) Canyon County (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 28, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Mesenbrink
LICENSE NO. E-487

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alsip Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 24 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4954
Local Reg. No. 183
Reg. Dist. No. 360

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 140 Canyon 001
b. CITY OR TOWN Nampa- Rural
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Locust Lane -R# 6 Nampa 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) Locust Lane- R# 6

3. NAME OF DECEASED (Type or Print) a. (First) RAY b. (Middle) E. c. (Last) BARRETT, Sr.

4. DATE OF DEATH (Month) (Day) (Year) November 22, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 12, 1891

9. AGE (In years last birthday) 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farming

11. BIRTHPLACE (State or foreign country) Balleyville Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Cal Barrett BIRTHPLACE Tennessee

14. MOTHER'S MAIDEN NAME Martha P. Allen BIRTHPLACE Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 42 1692

17. INFORMANT'S OWN SIGNATURE X Mrs Ray Barrett ADDRESS Nampa, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH 10 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Pulmonary emphysema. — years ?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 20 1967, *to* Nov 22, 1967, *that I last saw the deceased alive on* Nov. 22, 1967, *and that death occurred at* Approx. 9:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE Marion E Blough (Degree or title) MD

23b. ADDRESS 619 S Canyon, Nampa Idaho

23c. DATE SIGNED Nov 25, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) Nampa (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 29, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Jerry L. Kovach LICENSE NO. E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4955
Local Reg. No. 198
Reg. Dist. No. 360

Certificate of Death

RECEIVED DEC 7 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blakeley NursingHome 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) 310 Cleveland

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) ALEX
c. (Last) BROWN

4. DATE OF DEATH (Month) 11 (Day) 22 (Year) 67

5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 7, 1878
9. AGE (In years last birthday) 89 — IF UNDER 1 YEAR Months 5 Days 15 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Baraboo, Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel Brown — BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME Mary Mitchell — BIRTHPLACE Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 519-42-6345
17. INFORMANT'S OWN SIGNATURE Mrs. L. K. Hopper — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerosis & Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 8 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) — indefinite & gradual
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1965, *to* 11-22, 1967, *that I last saw the deceased alive on* 11-20, 1967, *and that death occurred at* 650 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Charles Kemick 280 (Degree or title) MD 1
23b. ADDRESS 1819 Ellis St Caldwell Idaho
23c. DATE SIGNED 12-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/27/67
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill
24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 6, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Lucy M. Flahiff — LICENSE NO. E393
FIRM NAME Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 11 1968

MAY 10 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 27 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 4056
Local Reg. No. 189
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Canyon 140 DEC 5 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa- Rural 000
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Nampa Drive In Theatre 000

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 136 Blaine St.

3. NAME OF DECEASED (Type or Print)
a. (First) LESLIE
b. (Middle) H.
c. (Last) PATE

4. DATE OF DEATH (Month) (Day) (Year) November 25, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 24, 1909

9. AGE (In years last birthday) 58
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Equipment Operator 08

10b. KIND OF BUSINESS OR INDUSTRY City of Nampa

11. BIRTHPLACE (State or foreign country) Buhl Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leslie H. Pate, Sr. BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME Grace Malone BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 09-7656

17. INFORMANT'S OWN SIGNATURE Phyllis Pate ADDRESS Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Second & Third degree Burns.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Found *19__, to __, 19__, that I last saw the deceased alive on __, 19__, and that death occurred at 9:00A.M. m., from the causes and on the date stated above.*

23a. SIGNATURE Henry C. Wesche (Degree or title) 560 M.D. 1

23b. ADDRESS Nampa Idaho

23c. DATE SIGNED 11-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 30, 1967

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery

24d. LOCATION (City, town, or county) Caldwell (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 4, 1967

REGISTRAR'S SIGNATURE Mrs. Martha Walmsley

25. EMBALMER Richard W. Meserbrink LICENSE NO. E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-8840

BIRTH NO.

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 4957
Local Reg. No. 194
Reg. Dist. No. 360

DEC 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
c. INSTITUTION STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) Route # 3

3. NAME OF DECEASED (Type or Print)
a. (First) CRYSTAL
b. (Middle) MAE
c. (Last) PURSIFULL

4. DATE OF DEATH (Month) (Day) (Year) 11 25 67

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Infant 1
8. DATE OF BIRTH Sept 17, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 2 Days 5 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant 02
10b. KIND OF BUSINESS OR INDUSTRY infant
11. BIRTHPLACE (State or foreign country) Caldwell, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Dennis Pursifull BIRTHPLACE Laurel Indiana
14. MOTHER'S MAIDEN NAME JoAnn Warne BIRTHPLACE Los Angeles, Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE X Dennis Pursifull ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

475X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Laryngeal edema due to

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) upper respiratory infection

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Don't know

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? brought to Hospital DOA

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 166 [signature] (Degree or title) 1
23b. ADDRESS Caldwell Ida
23c. DATE SIGNED 11-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 11/28/67
24c. NAME OF CEMETERY OR CREMATORY Canyon Hill
24d. LOCATION (City, town, or county) (State) Caldwell, Idaho

DATE REC'D BY LOCAL REG. Dec. 4, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Lucy M. Flahiff
LICENSE NO. E393

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4958
Local Reg. No. 196
Reg. Dist. No. 360

RECEIVED
DEC 7 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN Caldwell
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION Blakley's Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 141 b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell,
d. STREET ADDRESS (If rural, give location) 1223 Arthur St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Helen	M.	Griffiths	Nov. 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	May 13, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
00		Caldwell, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Merrick	New York	Ada M. George	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-24-8845B	Walter Griffiths Jr	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 170X Cerebral metastasis of

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of the breast

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 8 years since origin Breast resection

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1957 *to* 11-26, 1967, *that I last saw the deceased alive on* 11-25, 1967, *and that death occurred at* 0745 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Charles E Kenworthy 280	MD	1819 Ellis St Caldwell Ida.	12-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 29, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 6, 1967	Mrs. Martina Walmsley	Everett E Spencer	E-395

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4959
Local Reg. No. 186
Reg. Dist. No. 360

BIRTH NO.

RECEIVED

STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 112 CANYON DEC 1 1967 112
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) NAMPA
c. LENGTH OF STAY (in this place) 12 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 112
b. COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 307 16th AVE NO

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) ELLEN c. (Last) BENNETT

4. DATE OF DEATH (Month) NOV (Day) 26 (Year) 1967

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2

8. DATE OF BIRTH 3 - 7 - 1869

9. AGE (In years last birthday) 98 | IF UNDER 1 YEAR Months 8 Days 19 | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 01

10b. KIND OF BUSINESS OR INDUSTRY HOUSEWIFE

11. BIRTHPLACE (State or foreign country) CLAY COUNTY, WEST VA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WM. T. LOWTHER BIRTHPLACE WEST VA.

14. MOTHER'S MAIDEN NAME MATILDA A? SNIDER BIRTHPLACE WEST VA?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-60-6940

17. INFORMANT'S OWN SIGNATURE Mrs. Laurence Irving ADDRESS 307 16th Ave N.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 48h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Disease — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ischemic Ulcer Rt foot — 2 mo

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-21, 1967, *to* 11-25, 1967, *that I last saw the deceased alive on* 11-25, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Gaylon Olson MD 115 (Degree or title)

23b. ADDRESS NAMPA, IDAHO

23c. DATE SIGNED 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

24b. DATE 11-29-1967

24c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK

24d. LOCATION (City, town, or county) (State) TWIN FALLS, IDAHO

DATE REC'D BY LOCAL REG. Nov. 30, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER M. B. Shepherd LICENSE NO. 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 1 8 1967 Bureau of

State File No. 4960
Local Reg. No. 204
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 142 CANYON 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
c. LENGTH OF STAY (in this place) 17 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO 16
b. COUNTY CANYON 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 815 E. SHERIDAN

3. NAME OF DECEASED (Type or Print): a. (First) MARGARET b. (Middle) C. c. (Last) LANGAN

4. DATE OF DEATH (Month) (Day) (Year): NOV. 27, 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2

8. DATE OF BIRTH: SEPT. 8, 1892

9. AGE (In years last birthday): 75 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME-MAKER 01

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): ST. PAUL, MINNESOTA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: CHRISTOPHER STAHLMANN BIRTHPLACE: MINN.

14. MOTHER'S MAIDEN NAME: MARY E. JANSEN BIRTHPLACE: MINN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 470-01-8522

17. INFORMANT'S OWN SIGNATURE Anne C. Chatlain ADDRESS NAMPA, IDAHO

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary Embolism (Fat) — INTERVAL BETWEEN ONSET AND DEATH: 15 Min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture Pelvis — 17 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify) /

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Fell at home 01

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Nampa Canyon 142 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov 10-1967 3p m. 2

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Fell at home

22. *I hereby certify that I attended the deceased from* 11-10, 1967 *to* 11-17, 1967, *that I last saw the deceased alive on* 11-17, 1967, *and that death occurred at* 11:55 *from the causes and on the date stated above.*

23a. SIGNATURE Richard C. Iverson (Degree or title) 666 MD 1

23b. ADDRESS: NAMPA, IDAHO

23c. DATE SIGNED: 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3

24b. DATE: 11-28-67

24c. NAME OF CEMETERY OR CREMATORY: MT. CALVARY CEMETERY

24d. LOCATION (City, town, or county) (State): ST. PAUL, MINN.

DATE REC'D BY LOCAL REG.: Dec. 15, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: W. B. Shepherd — LICENSE NO. 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 19 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

F.NCK

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

State File No. 4961
Local Reg. No. 193
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 7 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakeley Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Parma
d. STREET ADDRESS (If rural, give location): Rt #1

3. NAME OF DECEASED (Type or Print)
a. (First): Wilhelmina
b. (Middle): Fredricka
c. (Last): Schmidt

4. DATE OF DEATH (Month) (Day) (Year): Nov. 27, 1967

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 12, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Eustis, Neb.
12. CITIZEN OF WHAT COUNTRY?: US.A

13. FATHER'S NAME: William Kaes — BIRTHPLACE: Ilsfeld, Germany
14. MOTHER'S MAIDEN NAME: Caroline Leihnseeder — BIRTHPLACE: Ilsfeld, Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-40-5608
17. INFORMANT'S OWN SIGNATURE: Sam Schmidt — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 154X Cancer rectum — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 5-11-66
19b. MAJOR FINDINGS OF OPERATION: Cancer rectum
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1964, 19__, *to* Nov. 27, 1967 *that I last saw the deceased alive on* 11-24, 1967, *and that death occurred at* 8 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 166 M.D.
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 11-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 1, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery
24d. LOCATION (City, town, or county): Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG.: Dec. 4, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4962
Local Reg. No. 188
Reg. Dist. No. 360

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Nampa
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 North 6th. Street

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 27 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1301 North 12th.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LOUIS	J.	ARCHULETA	November 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Mexican	Married 3	August 25, 1926	41				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Pipe Layer 11	Construction	Grand Junction Colorado	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Agapito Archuleta	New Mexico	Florence Madrid	Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	Korean 7	485	Mrs. Darlene Archuleta	Ida. Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Suffocation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cave-in of a trench
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident 1	Nampa Street 04	Nampa -	Canyon.	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
11- 27- 67 11:30 A.m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Working in a trench when it caved in.

22. *I hereby certify that I attended the deceased from* Inspection only, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Henry E. Wesche	560 MD 1	Nampa - Idaho	11-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Removal 3	Nov. 28, 1967	Mountainview Cemetery	Pocatello	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 4, 1967	Mrs. Martina Walmsley	Richard W. Messenbrink	E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 5 - 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 6 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 7 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 12 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

DEC 13 1967

(a) Knowingly supply false information to any one connected with completing a death certificate
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

AUG 3 1970

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4963
Local Reg. No. 195
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 7 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
LENGTH OF STAY (in this place) 3 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 4821 Denton

3. NAME OF DECEASED (Type or Print) a. (First) Oscar b. (Middle) T. c. (Last) Stromberg

4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 12, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Huntsville, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gustav Stromberg — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: unk. — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-05-8296A
17. INFORMANT'S OWN SIGNATURE: Mrs Leonard Gahenkrenner — ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis — 20 yrs
DUE TO (c) Acute Coronary Occlusion — 1 day

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Left upper lobe pneumonia — 3 wks
Nephrosclerosis & uremia — 1 month

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 Nov, 1967, *to* 27 Nov, 1967, *that I last saw the deceased alive on* 26 Nov, 1967, *and that death occurred at* 2:00A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: C B Riordan 443 (Degree or title) MD
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 4 Dec 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-30-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Dec. 6, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leo Jerred
LICENSE NO.: E-366
FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4964
Local Reg. No. 191
Reg. Dist. No. 360

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 142 Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
d. STREET ADDRESS (If rural, give location) 219½ 20th. St. South

3. NAME OF DECEASED (Type or Print) a. (First) Frances b. (Middle) Elmina c. (Last) Waltman

4. DATE OF DEATH (Month) 11 (Day) 28 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH July 15, 1880

9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Arkansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Col. Dick Johnson Waltman — BIRTHPLACE Penn.

14. MOTHER'S MAIDEN NAME Martha Olive Birch — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ----------

16. SOCIAL SECURITY NO. 519 58 9660 T

17. INFORMANT'S OWN SIGNATURE Ronald R. Waltman — ADDRESS Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma, Metastat— — INTERVAL BETWEEN ONSET AND DEATH 4 yr.

ANTECEDENT CAUSES endometrium.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-30- , 19 65 *to* 11-28- , 1967 , *that I last saw the deceased alive on* 11-28- , 1967 , *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Richard C. Thorn 666 (Degree or title) M.D.

23b. ADDRESS 619 So. Canyon, Nampa, Idaho

23c. DATE SIGNED 11/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-30-1967

24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn Cemetery

24d. LOCATION (City, town, or county) Nampa (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 4, 1967

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER G. W. Waters — LICENSE NO. E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 0 3 2000

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4965
Local Reg. No. 16
Reg. Dist. No. 520-521

BIRTH NO.

RECEIVED NOV 2 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 150 Caribou 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 41 So. 2cd. East 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 150 Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Soda Springs
d. STREET ADDRESS (If rural, give location): 41 So. 2cd East

3. NAME OF DECEASED (Type or Print): a. (First) b. (Middle) c. (Last): Thomas Poppleton Gunnell

4. DATE OF DEATH: (Month) (Day) (Year): October 31, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR: Months / Days	If UNDER 1 DAY: Hours / Min.
male	white	widower 2	Nov. 10, 1886	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer-retired 04	Farming	Wellsville, Utah	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas L. Gunnell		Sarah Poppleton	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Dean E. Gunnell	Soda Springs, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 8 years.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 19 59, *to* Oct 31, 19 67, *that I last saw the deceased alive on* Oct 5, 1967, *and that death occurred at* 6 A, m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen H. Light 634 M.D.	Soda Springs, Ida.	11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/4/67	Fairview Cemetery	Soda Springs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-21-67	Darhl Chenrett by	Theodore S. Allen	E370

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Allen Funeral Home

Morene Glenn

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 28 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4966
Local Reg. No. 12
Reg. Dist. No. 520-521

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 150 Caribou 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chestefield
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Caribou 150
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Chesterfield
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Louis Rolland Moore

4. DATE OF DEATH (Month) (Day) (Year) October 31, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widower 2
8. DATE OF BIRTH April 13, 1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer-retored 04
10b. KIND OF BUSINESS OR INDUSTRY farming
11. BIRTHPLACE (State or foreign country) Thurman, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Thomas J. Moore — BIRTHPLACE Kentucky
14. MOTHER'S MAIDEN NAME Harriett Roberts — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE x Thomas K. Moore — ADDRESS BaNCROFT, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occulsion — INTERVAL BETWEEN ONSET AND DEATH few minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Theodore S. Allen 583 (Degree or title) Coroner
23b. ADDRESS Soda Springs Idaho
23c. DATE SIGNED 11/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/3/67
24c. NAME OF CEMETERY OR CREMATORY Chesterfield Cemetery
24d. LOCATION (City, town, or county) (State) Chesterfield, Idaho

DATE REC'D BY LOCAL REG. 11-21-67
REGISTRAR'S SIGNATURE Darhl Churrett
25. EMBALMER Theodore S. Allen
LICENSE NO. E370

Federal Security Agency
United States Public Health Service
Form DH-63021 Norene Bunn
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 20 1979

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4967
Local Reg. No. 14
Reg. Dist. No. 520-521

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 150 Caribou 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caribou County Hospital 009

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 150
b. COUNTY Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bancroft
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last) Lawrence Charles Grimm

4. DATE OF DEATH (Month) (Day) (Year) October 31, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH April 12, 1889
9. AGE (In years last birthday) 78 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truckeer-retired 27
10b. KIND OF BUSINESS OR INDUSTRY Trucking
11. BIRTHPLACE (State or foreign country) Wilamette, Oregon
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME George M. Grimm — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Selina Tatro — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-42-8941
17. INFORMANT'S OWN SIGNATURE Margaret Grimm by Alice Larkins — ADDRESS Bancroft, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH few hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Had not attended him - dead when I checked him at approx. *19__, to _____, 19__, that I last saw the deceased alive on* Was Fine on 10/31/67 *, 19__, and that death occurred at* 1:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Russell Tigert 535 (Degree or title) MD 1
23b. ADDRESS Soda Springs Ida
23c. DATE SIGNED 10-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 11/2/67
24c. NAME OF CEMETERY OR CREMATORY Bancroft Cemetery
24d. LOCATION (City, town, or county) (State) Bancroft, Idaho

DATE REC'D BY LOCAL REG. 11-21-67
REGISTRAR'S SIGNATURE Darhl Cheyrett by Norene Bunn
25. EMBALMER Theodore P Allen
LICENSE NO. E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 12 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 4968
Local Reg. No. 17
Reg. Dist. No. 520-521

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 160 Caribou 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 160 Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Soda Springs
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Laura b. (Middle) Mable Dike c. (Last) Moore Hopkins

4. DATE OF DEATH (Month) (Day) (Year) November 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	May 15, 1890	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own home	Farragut, Iowa	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unknown		unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no			Walter Moore	Soda Springs, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 331 Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 27 Oct, 1967, *to* Nov 6, 1967, *that I last saw the deceased alive on* Nov 6, 1967 *and that death occurred at* 1:06 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Allen H. Tegart	534 M.D.	Soda Springs, Idaho	11/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/9/67	Fairview Cemetery	Soda Springs, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-8-67	Lorene Bunn	Herdase A Allen	E370

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Allen Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4969
Local Reg. No. 1760
Reg. Dist. No. 470

Certificate of Death

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 160
b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Oakley
d. STREET ADDRESS (If rural, give location) ******

3. NAME OF DECEASED (Type or Print)
a. (First) Maryette
b. (Middle) Dayley
c. (Last) Critchfield

4. DATE OF DEATH (Month) (Day) (Year) Nov. 2, 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH July 7, 1881
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Oakley, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Dayley — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Matilda Martindale — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-60-3082
17. INFORMANT'S OWN SIGNATURE Max Critchfield — ADDRESS Burley, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4280

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Cardiac Failure — INTERVAL BETWEEN ONSET AND DEATH min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) arteriosclerotic Heart
DUE TO (c) Disease — ?

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Acute cholecystitis c̄ Hydrops — 7 days.

19a. DATE OF OPERATION 11-1-67
19b. MAJOR FINDINGS OF OPERATION acute cholecystitis c̄ Hydrops
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) none
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) none
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) none

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) none m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1962 *19*__ *to* 11-2- *19*67, *that I last saw the deceased alive on* 11-1- *19*67, *and that death occurred at* 3:40 *m., from the causes and on the date stated above.*

23a. SIGNATURE R Sutton 514 (Degree or title) MDA
23b. ADDRESS Burley Ida
23c. DATE SIGNED 11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 11/6/67
24c. NAME OF CEMETERY OR CREMATORY Oakley Cemetery
24d. LOCATION (City, town, or county) (State) Oakley, Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE
25. EMBALMER [signature]
LICENSE NO. E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4970
Local Reg. No. 1761
Reg. Dist. No. 470

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 161 Cassia
b. CITY OR TOWN: Burley
c. LENGTH OF STAY IN THIS PLACE: 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 161 Cassia
c. CITY OR TOWN: Burley
d. STREET ADDRESS (If rural, give location): 3512 Hiland Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Wood b. (Middle) Lantz c. (Last) Trout

4. DATE OF DEATH: (Month) Nov. (Day) 5, (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: April 3, 1886

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 14

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Burlingame, Kansas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sylvester C. Trout
BIRTHPLACE: Pennsylvania

14. MOTHER'S MAIDEN NAME: Caroline R. Lantz
BIRTHPLACE: Hagerstown, Md.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 518-42-0884

17. INFORMANT'S OWN SIGNATURE: Bertha M Trout
ADDRESS: Burley, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 Hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — 10 yrs

DUE TO (c) Arteriosclerotic Myocarditis — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-4-67, 19—, *to* 11-5, 1967, *that I last saw the deceased alive on* 11-5, 1967, *and that death occurred at* 7:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 276 (Degree or title)

23b. ADDRESS: Burley Idaho

23c. DATE SIGNED: 11-7-67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/8/67

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Nov. 13 1967

REGISTRAR'S SIGNATURE: Beth A Pearson

25. EMBALMER: [signature]

LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 25 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4971
Local Reg. No. 1762
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 24 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia 503
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hosp. 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 161 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 1163 Grandview Addn.

3. NAME OF DECEASED (Type or Print)
a. (First) Evan
b. (Middle) Morgan
c. (Last) Thomas

4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH March 4, 1908
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired State Hiway
10b. KIND OF BUSINESS OR INDUSTRY Foreman
11. BIRTHPLACE (State or foreign country) Logan, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Evan M. Thomas — BIRTHPLACE Malad City, Ida.
14. MOTHER'S MAIDEN NAME Margaret Nelson — BIRTHPLACE Logan, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-12-1737
17. INFORMANT'S OWN SIGNATURE Helen Thomas — ADDRESS Burley

5271

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH 1 yr

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Emphysema 50 — 5-7 yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes Mellitus — 1-3 yr

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-27-63, 19__, *to* 11-13-67, 19__, *that I last saw the deceased alive on* 11-13-67, 19__, *and that death occurred at* 7 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 526 (Degree or title) MD
23b. ADDRESS Burley, Idaho
23c. DATE SIGNED 11-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 11/17/67
24c. NAME OF CEMETERY OR CREMATORY Pleasant View
24d. LOCATION (City, town, or county) (State) Burley, Idaho

DATE REC'D BY LOCAL REG. Nov. 20, 1967
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER [signature]
LICENSE NO. E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 27 1980

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

State File No. 4972
Local Reg. No. 1764
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 160 Cassia 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Strevell
c. LENGTH OF STAY (in this place) enroute
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 38 Oregon
b. COUNTY 555 Multnomah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Portland
d. STREET ADDRESS (If rural, give location) 2845 SE 119th

3. NAME OF DECEASED (Type or Print)
a. (First) Murney
b. (Middle) Clara
c. (Last) Loewen

4. DATE OF DEATH (Month) (Day) (Year) Nov. 21, 1967

5. SEX female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH June 19, 1900
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR: Months 5, Days 2 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Plymouth, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Herman Schmidt — BIRTHPLACE Nebraska
14. MOTHER'S MAIDEN NAME Angeline Gabel — BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. 541-46-0282
17. INFORMANT'S OWN SIGNATURE Len Ellertson — ADDRESS Vancouver, Wn.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured cervical vertebra — INTERVAL BETWEEN ONSET AND DEATH moment

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Severed spinal cord — moments

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 160 (STATE) Rural Cassia Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11 21 67 1:45 p.m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? auto accident.

2 Investigated

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 1:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Leslie L Fillmore 165 (Degree or title)
23b. ADDRESS Box 657 Burley, Ida
23c. DATE SIGNED 11-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Nov. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY Park Hill Cemetery
24d. LOCATION (City, town, or county) (State) Vancouver, Washington

DATE REC'D BY LOCAL REG. Dec. 4 1967
REGISTRAR'S SIGNATURE Beth H. Pearson
25. EMBALMER Ormund F Burch
LICENSE NO. E 471

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: McCULLOCH FUNERAL HOME

DEC 12 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

State File No. 4973
Local Reg. No. 1265
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (In this place): 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
d. STREET ADDRESS (If rural, give location): Cassia Hosp. Geriatrics

3. NAME OF DECEASED (Type or Print): a. (First) Bruce; b. (Middle) [illegible]; c. (Last) Clark

4. DATE OF DEATH: (Month) Nov. (Day) 21, (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Feb. 25, 1909

9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Oklahoma

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Clark — BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: ?

17. INFORMANT'S OWN SIGNATURE AND ADDRESS: Information taken from Hospital Records

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): ? acute pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: 1 day.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Cerebral vascular thrombosis — years

DUE TO (c): arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: ch. alcoholism — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) 7 (Day) 15 (Year) 66 (Hour) [illegible] m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-63, 19 66, *to* 11-21, 19 67, *that I last saw the deceased alive on* 11-21, 19 67, *and that death occurred at* 10:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] MD (Degree or title)

23b. ADDRESS: Burley, Idaho

23c. DATE SIGNED: 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 11/27/67

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Dec. 4 1967

REGISTRAR'S SIGNATURE: Burk H. Pearson

25. EMBALMER: [signature]

LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS By Physician.....

State File No. 4974
Local Reg. No. 1763
Reg. Dist. No. 470

Certificate of Death

RECEIVED DEC 5 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton (rural)
d. STREET ADDRESS (If rural, give location): Route 2, Box 115

3. NAME OF DECEASED (Type or Print)
a. (First): Helen
b. (Middle): Louise 070
c. (Last): PASLAY

4. DATE OF DEATH (Month) (Day) (Year): November 23, 1967

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 27, 1927
9. AGE (In years last birthday): 40 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Topeka, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Kelly Lewis — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Josephine Bleier — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - - - - -
16. SOCIAL SECURITY NO.: 513-24-2953
17. INFORMANT'S OWN SIGNATURE: Merrill D. Paslay — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*
(a) General Peritonitis Acute fulminating — INTERVAL BETWEEN ONSET AND DEATH: 7 Days
ANTECEDENT CAUSES
Due to Bowel obstruction - Resulting in — 12 Days
DUE TO (b) Segmental Large Bowel Resection — 11 Days.
DUE TO (c) Endometriosis Sv. Large Bowel — Unknown -

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 November, 1967, *to* 23 Nov, 1967, *that I last saw the deceased alive on* 23 Nov, 1967, *and that death occurred at* 6:15 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Chas M Lehman 526 (Degree or title): MD
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 24 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rochester Cemetery
24d. LOCATION (City, town, or county) (State): Topeka, Shawnee Co., Kansas

DATE REC'D BY LOCAL REG.: Dec. 4 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Charles L Persons
LICENSE NO.: E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4975
Local Reg. No. 1767
Reg. Dist. No. 470

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 161 Cassia 301
b. CITY OR TOWN Burley
(If outside corporate limits, write RURAL and give township)
DURATION OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 340 b. COUNTY Minidoka
c. CITY OR TOWN Heyburn
d. STREET ADDRESS (If rural, give location) R.F.D. # 2

3. NAME OF DECEASED (Type or Print) a. (First) Ben b. (Middle) c. (Last) Thoren

4. DATE OF DEATH (Month) (Day) (Year) Nov. 25, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH June 13, 1911

9. AGE (In years last birthday) 56 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Bellsburg, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 568-07-8539

17. INFORMANT'S OWN SIGNATURE Ada Thoren ADDRESS Heyburn, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarct — INTERVAL BETWEEN ONSET AND DEATH 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 8 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1964, *to* Nov. 25, 1967, *that I last saw the deceased alive on* Nov. 25, 1967 *and that death occurred at* 18 m., *from the causes and on the date stated above.*

23a. SIGNATURE John W. Stein M.D. (Degree or title) **23b. ADDRESS** Box 848 Burley Idaho **23c. DATE SIGNED** NOV. 30 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE 11/29/67

24c. NAME OF CEMETERY OR CREMATORY Pleasant View

24d. LOCATION (City, town, or county) (State) Burley, Idaho

DATE REC'D BY LOCAL REG. Dec 4 1967

REGISTRAR'S SIGNATURE Burt H. Pearson

25. EMBALMER Ruth Payne

LICENSE NO. E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 6 1967

DEC 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4976
Local Reg. No. 1768
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 16 Cassia
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (in this place) short
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 16 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Albion
d. STREET ADDRESS (If rural, give location) Albion

3. NAME OF DECEASED (Type or Print) a. (First) Isabella b. (Middle) Josephine c. (Last) Goodman

4. DATE OF DEATH (Month) Nov. (Day) 27, (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Nov. 7, 1893

9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY None

11. BIRTHPLACE (State or foreign country) Malta, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Telfer — BIRTHPLACE Scotland

14. MOTHER'S MAIDEN NAME Laura Payne — BIRTHPLACE Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-18-7544

17. INFORMANT'S OWN SIGNATURE Clyde W. Goodman — ADDRESS Albion, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Papillo-adeno carcinoma Thyroid — INTERVAL BETWEEN ONSET AND DEATH 37 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease — 10 years

1948

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-24, 1955, *to* Nov 27, 1967, *that I last saw the deceased alive on* Nov 24, 1967, *and that death occurred at* 5:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 283 (Degree or title) MD

23b. ADDRESS Burley Idaho

23c. DATE SIGNED Dec 5, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12/1/67

24c. NAME OF CEMETERY OR CREMATORY Albion Masonic Cemetery

24d. LOCATION (City, town, or county) (State) Albion, Cassia, Idaho

DATE REC'D BY LOCAL REG. Dec. 8, 1967

REGISTRAR'S SIGNATURE Burk H. Pearson

25. EMBALMER Jerry K. Lawson

LICENSE NO. E-522

FIRM NAME: Payne Mortuary-Burley, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED.
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 4977
Local Reg. No. 88
Reg. Dist. No. 210

RECEIVED STATE OF IDAHO
NOV 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater 302
b. CITY OR TOWN: Orofino
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Clearwater Valley Hosp. 023

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 180
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Thomas b. (Middle) B. c. (Last) Hazen

4. DATE OF DEATH: (Month) (Day) (Year) Nov. 6, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: May 2, 1889
9. AGE (In years last birthday): 78 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): rancher 04
10b. KIND OF BUSINESS OR INDUSTRY: cattle-grain
11. BIRTHPLACE (State or foreign country): Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Allen P. Hazen — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Adellia Martin — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-64-1156
17. INFORMANT'S OWN SIGNATURE: Allen N. Hazen ADDRESS: Orofino

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Nov, 1967, *that I last saw the deceased alive on* 6 Nov, 1967, *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Instrue Chamberlain M.D. 340 (Degree or title)
23b. ADDRESS: Orofino Idaho
23c. DATE SIGNED: 8 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 11-8-67
24c. NAME OF CEMETERY OR CREMATORY: Weseman
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Nov. 8, 1967
REGISTRAR'S SIGNATURE: June M. Lowell
25. EMBALMER: Lyle A. Stoltzmann
LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 15 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 4978
Local Reg. No. 89
Reg. Dist. No. 210

BIRTH NO.

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 180 Clearwater 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
c. LENGTH OF STAY IN THIS PLACE (If nonresident) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Clearwater Valley Hosp. 013

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 180 b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ahsahka-rural
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Earl	E.	Jones	Nov. 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	divorced 4	May 31, 1899	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
painter 21	construction	Hamilton, Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Louie Jones	Unk.	Mary Huddleston	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Tyler A. Strottmann	Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Embolism 4208

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD
DUE TO (c) Cardiac decompensation

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10 Nov, 1967, *to* 12 Nov, 1967, *that I last saw the deceased alive on* 12 Nov, 1967, *and that death occurred at* 2:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wayne Chamberlain 340	M.D.	Orofino, Idaho	15 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	11-18-67	Riverside	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 15, 1967	Jane M. Lowell	Tyler A. Strottmann	476

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4979
Local Reg. No. 91
Reg. Dist. No. 210

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 180 Clearwater 204
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
LENGTH OF STAY (in this place) 4 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) State Hospital North 074

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351 b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) DONALD b. (Middle) L. c. (Last) WICKERSHAM

4. DATE OF DEATH (Month) (Day) (Year) November 22, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH June 10, 1900

9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Meat cutter 21

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Nez Perce, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alvin Wickersham — BIRTHPLACE Kansas

14. MOTHER'S MAIDEN NAME Mary Jane Rinehart — BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) Unknown 0

16. SOCIAL SECURITY NO. 518-01-1316

17. INFORMANT'S OWN SIGNATURE Christine Powell — Records — ADDRESS Orofino, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

491X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Possible pulmonary infarction — Approximately one week

DUE TO (c) Decubiti — 3 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic brain syndrome associated with arteriosclerosis — 4 months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 31, 1967, *to* Nov. 22, 1967, *that I last saw the deceased alive on* Nov. 22, 1967, *and that death occurred at* 8:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D. 430

23b. ADDRESS Box 672, Orofino, Idaho

23c. DATE SIGNED Nov. 22, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE 11-27-67

24c. NAME OF CEMETERY OR CREMATORY Riverside

24d. LOCATION (City, town, or county) (State) Orofino, Idaho

DATE REC'D BY LOCAL REG. Dec. 1, 1967

REGISTRAR'S SIGNATURE June M. Powell

25. EMBALMER Fyke A. Gottman — LICENSE NO. 476

FIRM NAME GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 9 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4980
Local Reg. No. 90
Reg. Dist. No. 210

Certificate of Death

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 180 Clearwater 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino-rural
c. LENGTH OF STAY (in this place) months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Swaynes Addn. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 180
b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino-rural
d. STREET ADDRESS (If rural, give location) Swaynes Addn.

3. NAME OF DECEASED (Type or Print)
a. (First) Lorene
b. (Middle)
c. (Last) Watson

4. DATE OF DEATH (Month) (Day) (Year) Nov. 22, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) divorced 4
8. DATE OF BIRTH Dec. 23, 1917
9. AGE (In years last birthday) 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife 01
10b. KIND OF BUSINESS OR INDUSTRY own home
11. BIRTHPLACE (State or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Calvin Dunkle — BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Myrtle Daharsh — BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 552-40-2967
17. INFORMANT'S OWN SIGNATURE J. Richard Almy — ADDRESS Box 312 Orofino

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

976X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) gun shot wound in head — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) suicide 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) home 01
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 180 **(STATE)** Orofino Clearwater Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-22-67 2-4-pm 2
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 2-4 p m., *from the causes and on the date stated above.*

23a. SIGNATURE H.K. Brandon 583 (Degree or title) acting Corner 4
23b. ADDRESS Orofino, Idaho
23c. DATE SIGNED 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE 11-25-67
24c. NAME OF CEMETERY OR CREMATORY Peckham-Dakan F. H.
24d. LOCATION (City, town, or county) (State) Caldwell, Canyon Co. Idaho

DATE REC'D BY LOCAL REG. Dec. 1, 1967
REGISTRAR'S SIGNATURE June M. Powell
25. EMBALMER Ty C A Stottmann
LICENSE NO. 476

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gilbert's funeral chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4981
Local Reg. No. 92
Reg. Dist. No. 210

67-10894 RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 180 Clearwater 406
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino
LENGTH OF STAY (In this place) 5½ hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Clearwater Valley Hosp. 073

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 88
b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pierce
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) James c. (Last) McGee

4. DATE OF DEATH (Month) (Day) (Year): Nov. 25, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Nov. 25, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours: 5 | Min.: 21

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Orofino, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward McGee — BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Anne Hiller — BIRTHPLACE: Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: X Edward J. McGee — ADDRESS: Pierce, Idaho

18. CAUSE OF DEATH 7235
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hyaline membrane disease — INTERVAL BETWEEN ONSET AND DEATH: 6 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity (31 wk)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-25, 1967 *to* 11-25, 1967, *that I last saw the deceased alive on* 11-25, 1967, *and that death occurred at* 3:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 038

23b. ADDRESS: Orofino, Idaho

23c. DATE SIGNED: 11 30 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 11-27-67

24c. NAME OF CEMETERY OR CREMATORY: Riverside

24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Dec. 1, 1967

REGISTRAR'S SIGNATURE: June M. Powell

25. EMBALMER: Lyle A. Strassmann — LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4982
Local Reg. No. 47
Reg. Dist. No. 680

RECEIVED NOV 16 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 190 custer
b. CITY OR TOWN Rural-Clayton
c. LENGTH OF STAY IN (If outside corporate limits, write RURAL and give this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Pesch Creek (10 Mi. W. Clayton)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 28 Nebr
b. COUNTY 555 Phelps
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Holdrege
d. STREET ADDRESS (If rural, give location) 206 Waters Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) BELLE
b. (Middle)
c. (Last) CHRISTIANSEN

4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Sept. 12, 1897

9. AGE (In years last birthday) 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) nurse 13

10b. KIND OF BUSINESS OR INDUSTRY nursing

11. BIRTHPLACE (State or foreign country) Rock Co. Nebr.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William H. Hart
BIRTHPLACE Iowa

14. MOTHER'S MAIDEN NAME Clara D. Wallace
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 508-18-5102

17. INFORMANT'S OWN SIGNATURE Clarence Christiansen ADDRESS 206 Waters Ave Holdrege Nebr

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Internal Injuries — INTERVAL BETWEEN ONSET AND DEATH: 30 Min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto Accident, Crushing her chest
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Pesch Creek RD

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 190 **(STATE)** Clayton Custer, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 11, 67 12A. m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2

21f. HOW DID INJURY OCCUR? Auto accident with car crushing her chest,

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* DID NOT SEE ALIVE 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Glen W. Reed (Degree or title) Coroner 583 4

23b. ADDRESS Box 96 Challis, Idaho

23c. DATE SIGNED 11/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3

24b. DATE 11/12/67

24c. NAME OF CEMETERY OR CREMATORY Prairie Home cemetery

24d. LOCATION (City, town, or county) (State) Holdrege, Nebr.

DATE REC'D BY LOCAL REG. 11/15/67

REGISTRAR'S SIGNATURE Mrs. Laurene J. Mulder

25. EMBALMER Keith Bird Keith Bird

LICENSE NO. E-373

FIRM NAME: Bird Funeral Home, Hailey, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4983
Local Reg. No. 72
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 200 Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural- Grand View
c. LENGTH OF STAY (In this place): 00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): C. J. Strike Dam 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 00 Unknown
b. COUNTY: 000 Unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Unknown
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print): a. (First) UNKNOWN b. (Middle) c. (Last) MAN

4. DATE OF DEATH (Month) (Day) (Year): Uknown

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Unknown 0

8. DATE OF BIRTH: Unknown

9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Unknown — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Arthur Smith — ADDRESS: Mt. Home

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Presumed Drowned — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (c) — INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Reservoir 18

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 200 **(STATE)**: Rural - Grand View, Elmore, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Unknown m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR? Victim's body found floating in reservoir

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith 583 (Degree or title): Coroner 4

23b. ADDRESS: Mountain Home, Idaho

23c. DATE SIGNED: 10/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 10/11/67

24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery

24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Nov 17 1967

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature] — LICENSE NO.: E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4984
Local Reg. No. 73
Reg. Dist. No. 380 391

BIRTH NO. 67-6075

RECEIVED NOV 22 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 200 Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 13 Idaho
b. COUNTY: 370 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): Jerome Labor Camp

3. NAME OF DECEASED (Type or Print): a. (First) JUVENAL b. (Middle) c. (Last) ESTRADA

4. DATE OF DEATH: (Month) (Day) (Year): October 20, 1967

5. SEX: Male

6. COLOR OR RACE: Spanish American

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): N. Married

8. DATE OF BIRTH: June 3, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months | Days: 17 | IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Weiser, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Santos Estrada — BIRTHPLACE: Texas

14. MOTHER'S MAIDEN NAME: Maria Rocha — BIRTHPLACE: Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Santos Estrada — ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

5788

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Dehydration and diarrhea
DUE TO (c) Intestinal infection

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Did not see alive, doctor diagnosed *alive on* ____, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.* — *I last saw the deceased*

23a. SIGNATURE: Arthur Smith 583 (Degree or title): Coroner 4
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 10/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 10/21/67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Nov 17 1967
REGISTRAR'S SIGNATURE:
25. EMBALMER: Arthur Smith
LICENSE NO.: E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4985
Local Reg. No.
Reg. Dist. No.

RECEIVED NOV 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore
b. CITY OR TOWN Glenns Ferry
d. FULL NAME OF HOSPITAL OR INSTITUTION 201 East Snak River Ave.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Elmore
c. CITY OR TOWN Glenns Ferry
d. STREET ADDRESS (If rural, give location) 201 East Snake River Ave.

3. NAME OF DECEASED (Type or Print) a. (First) MRS. b. (Middle) SELMA c. (Last) MINNIE ROFF

4. DATE OF DEATH (Month) (Day) (Year) October 24, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 27, 1910
9. AGE (In years last birthday) 57 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook 01
10b. KIND OF BUSINESS OR INDUSTRY Restuarant
11. BIRTHPLACE (State or foreign country) Soldier, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Otto Krahn BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Bolt BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-28-6226
17. INFORMANT'S OWN SIGNATURE Walter Roff ADDRESS Glenns Ferry

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of ovary — INTERVAL BETWEEN ONSET AND DEATH 6 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 9, 1967, *to* Oct 24, 1967, *that I last saw the deceased alive on* Oct 24, 1967, *and that death occurred at* 2:00 p m., *from the causes and on the date stated above.*

23a. SIGNATURE Wendell Ruhter (Degree or title) MD
23b. ADDRESS Glenns Ferry Idaho
23c. DATE SIGNED Oct 27, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 10/27/67
24c. NAME OF CEMETERY OR CREMATORY Glenn Rest Cemetery
24d. LOCATION (City, town, or county) (State) Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG. Nov 5-67
REGISTRAR'S SIGNATURE Mary Sullivan
25. EMBALMER H. Verl Humpherys
LICENSE NO. E- 502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 1 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4986
Local Reg. No. 74
Reg. Dist. No. 380-391

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 185 West 12th South

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
d. STREET ADDRESS (If rural, give location): 185 West 12th South

3. NAME OF DECEASED (Type or Print): a. (First) JACK b. (Middle) B. c. (Last) PENARD

4. DATE OF DEATH: (Month) (Day) (Year) October 31, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Jan. 25, 1870

9. AGE (In years last birthday): 97 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Rancher

10b. KIND OF BUSINESS OR INDUSTRY: Stock

11. BIRTHPLACE (State or foreign country): Dubuque, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-60-0738

17. INFORMANT'S OWN SIGNATURE: x Jean Barton
ADDRESS: Mt. Home, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7824

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] M.D. (Degree or title)

23b. ADDRESS: Mountain Home, Idaho

23c. DATE SIGNED: 11/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/4/67

24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery

24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Nov 17 1967

REGISTRAR'S SIGNATURE: [illegible] Anderson

25. EMBALMER: H. Neil Humphreys

LICENSE NO.: E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4987
Local Reg. No. 76
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED NOV 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 200 Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Mtn. Home
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 6 miles E on Hiway 30 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 51 Wyoming
b. COUNTY 555 Platte
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Guernsey
d. STREET ADDRESS (If rural, give location) Guernsey

3. NAME OF DECEASED (Type or Print) a. (First) MRS. b. (Middle) VIOLA JEAN c. (Last) LEWIS

4. DATE OF DEATH (Month) (Day) (Year) November 5, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH March 14, 1927

9. AGE (In years last birthday) 40 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Business woman 19

10b. KIND OF BUSINESS OR INDUSTRY Restaurant

11. BIRTHPLACE (State or foreign country) Battleground, Washington

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Oscar Koitzsch
BIRTHPLACE Wash.

14. MOTHER'S MAIDEN NAME Marie Harrison
BIRTHPLACE Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Verna E. Koitzsch
ADDRESS Kirkland, Wa.

18. CAUSE OF DEATH 8164
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Chest Trauma
Hemothorax
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple Rib Fractures
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: seconds

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 06

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 200 **(STATE)** Rural - Mountain Home, Elmore, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 5, 1967 2:00AM

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Victim driver of car involved in head-on crash

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation, that I last saw the deceased *alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Clifton Smith 583 (Degree or title) Coroner 4

23b. ADDRESS Mountain Home, Idaho

23c. DATE SIGNED 11/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 11/7/67

24c. NAME OF CEMETERY OR CREMATORY Guernsey, Wyoming

24d. LOCATION (City, town, or county) (State) Guernsey, Wyoming

DATE REC'D BY LOCAL REG. Nov 17 1967

REGISTRAR'S SIGNATURE [signature]

25. EMBALMER A. Verl Humphreys
LICENSE NO. E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 30 1967

DEC 1 1967

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4988
Local Reg. No. 76
Reg. Dist. No. 380 391

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 22 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 200 Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 080
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Nursing Home 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 200 Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) King Hill
d. STREET ADDRESS (If rural, give location) King Hill

3. NAME OF DECEASED (Type or Print)
a. (First) CLYDE
b. (Middle) ENNIS
c. (Last) BOTT

4. DATE OF DEATH (Month) (Day) (Year) November 8, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Mar. 10, 1875
9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer - Retired 04
10b. KIND OF BUSINESS OR INDUSTRY Fruit
11. BIRTHPLACE (State or foreign country) Albany, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE
14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Cecil E. Bott ADDRESS King Hill, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic brain syndrome years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION Recent fract. left hip
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1966, *to* Nov 8, 1967, *that I last saw the deceased alive on* Nov. 7, 1967, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Malone W. Kedach 289 (Degree or title) NPDI
23b. ADDRESS Mountain Home Idaho
23c. DATE SIGNED 11-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/10/67
24c. NAME OF CEMETERY OR CREMATORY Glenn Rest Cemetery
24d. LOCATION (City, town, or county) (State) Glenns Ferry, Idaho

DATE REC'D BY LOCAL REG. Nov 17 1967
REGISTRAR'S SIGNATURE T. Anderson
25. EMBALMER Arthur Smith
LICENSE NO. E-403

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 27 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4989
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 200 Elmore 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Glenns Ferry 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 200 Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Glenns Ferry
d. STREET ADDRESS (If rural, give location): Glenns Ferry

3. NAME OF DECEASED (Type or Print): a. (First) BEVERLY b. (Middle) HENDERSON c. (Last) ROSE

4. DATE OF DEATH (Month) (Day) (Year): November 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Dec. 19, 1896

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Laborer

10b. KIND OF BUSINESS OR INDUSTRY: 06

11. BIRTHPLACE (State or foreign country): Thatcher, Arizona

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas E. Rose
BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Louise Castle
BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World War 1

16. SOCIAL SECURITY NO.: 519-34-2918

17. INFORMANT'S OWN SIGNATURE: Veterans Administration Records
ADDRESS

4201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Heart Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19__, *to* Investigation Only, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith 583 (Degree or title): Coroner 4

23b. ADDRESS: Mountain Home, Idaho

23c. DATE SIGNED: 11/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 11/10/67

24c. NAME OF CEMETERY OR CREMATORY: St. Johns, Arizona

24d. LOCATION (City, town, or county) (State): St. Johns, Arizona,

DATE REC'D BY LOCAL REG.: Nov 28-67

REGISTRAR'S SIGNATURE: Mary Sullivan

25. EMBALMER: Arthur Smith

LICENSE NO.: E-403

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: DEC 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4990
Local Reg. No. 77
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 200 Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 320
b. COUNTY Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Bruneau
d. STREET ADDRESS (If rural, give location) 5 miles South Bruneau

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RALPH	FISK	CARTER	November 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	May 10, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired 29		Ogden, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
JPF Carter		Rosetta Howard	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-10-0829	Walter L. Carter	Pocatello, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 5272 Chronic obstructive lung disease & early pneumonia.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] M.D.	Mountain Home, Idaho	11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11/21/67	Wilford Cemetery	St. Anthony, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 17 1967	[signature]	F. Neal Humphrey	E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 14 1967 Bureau of Vital Statistics

State File No. 4991
Local Reg. No. 78
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 200 Elmore 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 06 Colorado
b. COUNTY 555 El Paso
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Colorado Springs
d. STREET ADDRESS (If rural, give location) 703 North Farragut

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE
b. (Middle) RUFUS
c. (Last) LUCHT

4. DATE OF DEATH (Month) (Day) (Year) November 25, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 18, 1911
9. AGE (In years last birthday) 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance 24
10b. KIND OF BUSINESS OR INDUSTRY Adjuster
11. BIRTHPLACE (State or foreign country) Grand Mound, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry G. Lucht — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Ida Mae Barber — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) World War 11 4
16. SOCIAL SECURITY NO. 479-12-2169
17. INFORMANT'S OWN SIGNATURE Mrs. George R. Lucht — ADDRESS Colorado Springs Colo.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 718 (Degree or title) M.D.
23b. ADDRESS Mountain Home, Idaho
23c. DATE SIGNED 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11/27/67
24c. NAME OF CEMETERY OR CREMATORY Colorado Springs, Colo.
24d. LOCATION (City, town, or county) (State) Colorado Springs, Colorado

DATE REC'D BY LOCAL REG. Dec 8 1967
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER H. Neil Humphrey — LICENSE NO. E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4992
Local Reg. No. 28
Reg. Dist. No. 540

RECEIVED NOV 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 210 Franklin 188
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
c. LENGTH OF STAY (in this place) 88
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 210
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston RFD
d. STREET ADDRESS (If rural, give location) Fairview

3. NAME OF DECEASED (Type or Print)
a. (First) Bertha
b. (Middle) Estella
c. (Last) Thompson Whittle

4. DATE OF DEATH (Month) (Day) (Year) Nov. 2, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 6, 1879
9. AGE (In years last birthday) 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Richmond, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Thompson — BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Mary Ellen Isaacson — BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Merlin J. Whittle — ADDRESS Fairview, Idaho

18. CAUSE OF DEATH 584X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cholecystitis and cholelithiasis — INTERVAL BETWEEN ONSET AND DEATH 15 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/8/52, 19__, *to* 11/2/67, 19__, *that I last saw the deceased alive on* 11/1/67, 19__, *and that death occurred at* 12:10 m. *from the causes and on the date stated above.*

23a. SIGNATURE 214 (Degree or title) Leo R. Hawkes M.D.
23b. ADDRESS Preston, Idaho
23c. DATE SIGNED 11/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery
24d. LOCATION (City, town, or county) (State) Fairview, Idaho

DATE REC'D BY LOCAL REG. 11-6-1967
REGISTRAR'S SIGNATURE Eppie W. Brower
25. EMBALMER Douglas S. Webb — LICENSE NO. 488

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4993
Local Reg. No. 29
Reg. Dist. No. 540

BIRTH NO.

RECEIVED NOV 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Franklin 110
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
LENGTH OF STAY (in this place): 10 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 216 b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
d. STREET ADDRESS (If rural, give location): 157 North 1st West

3. NAME OF DECEASED (Type or Print): a. (First) Hyrum b. (Middle) Rasmus c. (Last) Nelson

4. DATE OF DEATH (Month) (Day) (Year): Nov. 9, 1967

5. SEX: ~~Female~~ male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Nov. 14, 1886

9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (Retired) 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Brigham City, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Nels Nelson — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Bodell Hansen — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 10 7012

17. INFORMANT'S OWN SIGNATURE: Hennemore Nelson — ADDRESS: Preston Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ——, 19—, *to* ——, 19—, *that I last saw the deceased alive on* Oct, 1967, *and that death occurred at* 8 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Leo R Hawker M.D. 214 (Degree or title)

23b. ADDRESS: Preston Ida.

23c. DATE SIGNED: 11/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 13, 1967

24c. NAME OF CEMETERY OR CREMATORY: Cleveland Cemetery

24d. LOCATION (City, town, or county) (State): Cleveland, Idaho

DATE REC'D BY LOCAL REG.: 11-13-67

REGISTRAR'S SIGNATURE: Effie W. Brower

25. EMBALMER: Douglas S. Webb — LICENSE NO.: 488

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

AUG 1 4 1990

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 4994
Local Reg. No. 30
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 216 Franklin 125
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
c. LENGTH OF STAY (in this place) 25 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 216
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location) 340 South 2nd East

3. NAME OF DECEASED (Type or Print) a. (First) b. (Middle) c. (Last): Nellie Adella Bergquist Jepsen

4. DATE OF DEATH (Month) (Day) (Year): Nov. 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER A DAY: Hours	Min.
Female	White	Widowed 2	October 19, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Mink Creek, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Adolph F. Bergquist — BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Pernilla Nelson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Fannie Jepsen — ADDRESS: Preston, Idaho

18. CAUSE OF DEATH 3344

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Senility

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Hypostatic pneumonia

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 2/19, 19 67, *to* Nov. 12, 19 67, *that I last saw the deceased alive on* Nov. 11, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 214: Lee R. Hawkes M. D.

23b. ADDRESS: Preston, Idaho

23c. DATE SIGNED: Nov. 16, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 15, 1967

24c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery

24d. LOCATION (City, town, or county) (State): Preston, Idaho

DATE REC'D BY LOCAL REG.: 11-16-67

REGISTRAR'S SIGNATURE: Eppie W. Brower

25. EMBALMER: Douglas S. Webb — LICENSE NO.: 488

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4995
Local Reg. No. 31
Reg. Dist. No. 540

BIRTH NO.

RE~ DEC 1 8 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 210 Franklin 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 Highway 36, northeast of Preston

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 040
b. COUNTY Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Montpelier
d. STREET ADDRESS (If rural, give location) 251 North 6th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Brian	Douglas	Williams	Nov. 19 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	White	Never married	May 12, 1964	3		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Small Child 02		Ogden, Utah	U.S.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Douglas G. Williams	Provo, Utah	Nancy Taggart	Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Douglas G. Williams	Montpelier, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Crushed Skull — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Auto accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Accident	Highway 36 06	Preston	Franklin	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 10 35 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583		11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 21, 1967	Washington Heights Mem. Ogden City Cemetery	Ogden, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-21-67	Eppie W. Brouwer	Atherton Webb	316

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 17 2009

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 14 2015

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4996
Local Reg. No. 72
Reg. Dist. No. 651

BIRTH NO.

RECEIVED Bureau of Vital Statistics DEC 5 1967

1. PLACE OF DEATH
a. COUNTY 220 Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Ashton
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Ashton Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 03 Arizona
b. COUNTY 255
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Scottsdale
d. STREET ADDRESS (If rural, give location) 6905 F East Osborn

3. NAME OF DECEASED (Type or Print) a. (First) Byron b. (Middle) A. c. (Last) Tanberg

4. DATE OF DEATH (Month) (Day) (Year) Oct. 25, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 3, 1916

9. AGE (In years last birthday) 51
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Implement Dealer 22

10b. KIND OF BUSINESS OR INDUSTRY Farm Imp.

11. BIRTHPLACE (State or foreign country) Manston, Minnesota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Carl Tanberg
BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME Sophie Aigner
BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 468-14-4716

17. INFORMANT'S OWN SIGNATURE Family Records - Robert Bean
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic myelogenous leukemia — 10 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 Sept, 1967, to 25 Oct, 1967, *that I last saw the deceased alive on* 25 Oct, 1967, *and that death occurred at* 4:20 P m., *from the causes and on the date stated above.*

23a. SIGNATURE W. A. Mitcher (Degree or title) M.D.

23b. ADDRESS Ashton, Idaho

23c. DATE SIGNED 30 Nov '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 3

24c. NAME OF CEMETERY OR CREMATORY

24d. LOCATION (City, town, or county) (State) Pelican Rapids, Minnesota

DATE REC'D BY LOCAL REG. 4 Dec 67

REGISTRAR'S SIGNATURE M. L. Hansen

25. EMBALMER Robert O. Bean

LICENSE NO. E-456

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 36-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician I did not receive this certificate from the mortician until 29 Nov '67

[illegible], M.D.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 4997
Local Reg. No. 70
Reg. Dist. No. 650

RECEIVED NOV 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 221 Fremont 080
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont General Hosp. 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 13 Idaho
b. COUNTY 221 Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) 205 W. Main

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
PERRY	OLSON	MORTON	1 November 67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Divorced 4	7 May 1893	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06		Pleasant Hill, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James T. Morton	Carthage, Illinois	Adie DeCamp	Pleasant Hill, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
	518-18-6636	Winnie Nagle	RFD#2 St. Anthony, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchogenic Ca with metastases — INTERVAL BETWEEN ONSET AND DEATH: 10 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cirrhosis of lung — 30 yrs
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Tuberculosis — 2 mos

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 8-22, 1967, *to* 11-1, 1967, *that I last saw the deceased alive on* 11-1, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lloyd Barnett 030 M. D.	St. Anthony, Idaho	Nov. 3, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	4 Nov 67	Wilford Cemetery	St. Anthony, RFD#1, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
5 Nov 67	M. L. Hansen	M. L. Hansen	E-354

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: Hansen Memorial Chapel

NOV 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 4998
Local Reg. No. 71
Reg. Dist. No. 651

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 27 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 220 Fremont 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Macks Inn
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 331
b. COUNTY: Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 125 South 1st West

3. NAME OF DECEASED (Type or Print)
a. (First): Luara
b. (Middle): Annabell Wynn
c. (Last): Thompson

4. DATE OF DEATH (Month) (Day) (Year): November 2, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: January 20, 1903
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lyons, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George B. Wynn — BIRTHPLACE: Cedar Falls, Iowa
14. MOTHER'S MAIDEN NAME: Cora Straight — BIRTHPLACE: Modale, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: J. O. Thompson — ADDRESS: Rexburg, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5811

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Alcoholism & fatty

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): metamorphosis, liver

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: T. Mitchell MD — 746 (Degree or title)
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/6/67
24c. NAME OF CEMETERY OR CREMATORY: Sugar City
24d. LOCATION (City, town, or county) (State): Sugar City Madison Idaho

DATE REC'D BY LOCAL REG.: 21 Nov 67
REGISTRAR'S SIGNATURE: M. L. Hansen
25. EMBALMER: James R Flamm — LICENSE NO. E-477

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 3 1968

SEP 22 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 31 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 4999
Local Reg. No. 68
Reg. Dist. No. 661

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 220 Fremont 000
b. CITY OR TOWN Chester (Rural) (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Highway 191 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 33 b. COUNTY Madison
c. CITY OR TOWN Rexburg
d. STREET ADDRESS (If rural, give location) 171 College Avenue

3. NAME OF DECEASED (Type or Print) a. (First) LOUISE b. (Middle) PERRY c. (Last) DIETRICH

4. DATE OF DEATH (Month) (Day) (Year) November 10, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH September 16, 1910
9. AGE (In years last birthday) 57 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Roosevelt, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Alonzo Don Carlos Perry BIRTHPLACE
14. MOTHER'S MAIDEN NAME Eliza O. Remington BIRTHPLACE Paradise, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-20-3140
17. INFORMANT'S OWN SIGNATURE Leona Dietrich ADDRESS Rexburg, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive injuries — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hiway 1 mile north
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 220 (STATE) 06 Chester Fremont Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11 10 67 6:30PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2
21f. HOW DID INJURY OCCUR? Collision with Logging Truck

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, and that death occurred at DOA m., from the causes and on the date stated above.*

23a. SIGNATURE Paul Cornell 583 (Degree or title) CORONER 4
23b. ADDRESS P. O. Box 123 St. Anthony, Idaho
23c. DATE SIGNED 11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/14/67
24c. NAME OF CEMETERY OR CREMATORY Rexburg
24d. LOCATION (City, town, or county) (State) Rexburg Madison Idaho

DATE REC'D BY LOCAL REG. 14 Nov 67
REGISTRAR'S SIGNATURE M. L. Hansen
25. EMBALMER Bennett W. Flamm LICENSE NO. E347
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5000
Local Reg. No. 67
Reg. Dist. No. 651

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 220 Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Rural Chester
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Highway 191

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 331 Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rexburg
d. STREET ADDRESS (If rural, give location) 171 College Avenue

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
HENRY	VALENTINE	DIETRICH	November 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	May 10, 1912	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Real Estate Agent 24		Rexburg, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gottfred Dietrich	Germany	Rosa Lena Baur	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-07-3919	Jean Valentine Dietrich	Rexburg, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Injuries

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Automobile Accident

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13	(COUNTY) 220	(STATE)
Accident	1 mi North chester	06 Chester	Fremont	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
11 10 67 6:30 PM		Collision with Logging Truck

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* DOA *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul Rowell	583 CORONER 4	P. O. Box 123 St. Anthony, Ida	11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/14/67	Rexburg	Rexburg Madison Idaho

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
14 Nov 67	M. L. Hansen	Kenneth R. Flamm	E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 6 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

NOV 13 1981

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 2 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5001
Local Reg. No. 67
Reg. Dist. No. 650

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 221
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 082 Fremont General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Anthony
d. STREET ADDRESS (If rural, give location): 926 West 2nd South

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MARY	ELLIOTT	BATES	Nov., 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	Caucasian	Widow 2	20 Sept 1880			

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Yorkshire, England	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Elliott	England	Bertha Littlewood	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Gene Bates	St. Anthony, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Pneumonia, Broncho	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Senility	
DUE TO (c)	Exercise Restriction	1 month
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Fracture simple, sub-trochanteric left femur	1 month

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 19 59, *to* November 13 1967, *that I last saw the deceased alive on* 11/13 1967, *and that death occurred at* 9:00a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert R. Klemt, M.D. 284	325 East Main, St. Anthony, Idaho	11/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	16 Nov 67	Riverview Cemetery	St. Anthony, Fremont, Idaho

DATE RECEIVED BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
15 Nov 67	M. L. Hansen	M. L. Hansen	E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

DUTIES:

NOV 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 14 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

State File No. 5002
Local Reg. No. 73
Reg. Dist. No. 651

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Fremont 220 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Near Island Park
c. STATE OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): In Automobile 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 410 Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Felt
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): MERRILL
b. (Middle): PHIL
c. (Last): BROWER

4. DATE OF DEATH (Month) (Day) (Year): November 20, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: May 28, 1938
9. AGE (In years last birthday): 29 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Rigby, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Merrill Brower — BIRTHPLACE: Felt, Idaho
14. MOTHER'S MAIDEN NAME: Zelda Merle Finn — BIRTHPLACE: Rigby, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ———
16. SOCIAL SECURITY NO.: 519-44-6531
17. INFORMANT'S OWN SIGNATURE: X Merrill Brower — ADDRESS: Felt, Idaho

18. CAUSE OF DEATH 4222
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocarditis, focal — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 12:30 pm., from the causes and on the date stated above.*

23a. SIGNATURE: John N. Mitchell 746 (Degree or title): M.D.
23b. ADDRESS: L.P.L. Hosp. Idaho Fells, Ida
23c. DATE SIGNED: 12/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 24 Nov. 67
24c. NAME OF CEMETERY OR CREMATORY: Cache - Clawson Cemetery
24d. LOCATION (City, town, or county) (State): Tetonia, Teton Co., Idaho

DATE REC'D BY LOCAL REG.: 4 Dec 67
REGISTRAR'S SIGNATURE: M. L. Jansen
25. EMBALMER: Robert Bean — LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bean Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5003
Local Reg. No. 74
Reg. Dist. No. 630

BIRTH NO.

DEC 1 5 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Fremont 221
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
c. LENGTH OF STAY (in this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Fremont General Hospital 082

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 221 Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony (Rural)
d. STREET ADDRESS (If rural, give location) RFD#2

3. NAME OF DECEASED (Type or Print) a. (First) JOSEPH b. (Middle) ROY c. (Last) ORME

4. DATE OF DEATH (Month) (Day) (Year) Nov., 29, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH June 3, 1894
9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer and farmer
10b. KIND OF BUSINESS OR INDUSTRY 21
11. BIRTHPLACE (State or foreign country) Tooele, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Samuel W. Orme BIRTHPLACE Tooele, Utah
14. MOTHER'S MAIDEN NAME Mary Agnes Smith BIRTHPLACE Tooele, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 529-36-7280
17. INFORMANT'S OWN SIGNATURE Vivian N. Orme ADDRESS St. Anthony, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) R H D & aortic insufficiency 5 yrs

DUE TO (c) 0

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
CVA (R) middle cerebral 3 wks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 63, *to* Nov, 19 67, *that I last saw the deceased alive on* Nov 28, 1967, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Lloyd Burnett 030 (Degree or title) M.D.
23b. ADDRESS St Anthony Ida
23c. DATE SIGNED 12-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 2 Dec 67
24c. NAME OF CEMETERY OR CREMATORY Wilford Cemetery
24d. LOCATION (City, town, or county) (State) St. Anthony, RFD#1, Idaho

DATE RECD BY LOCAL REG. 7 Dec 67
REGISTRAR'S SIGNATURE M. L. Hansen
25. EMBALMER M. L. Hansen
LICENSE NO. E-354

FIRM NAME: Hansen Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5004
Local Reg. No. 33
Reg. Dist. No. 240-341

BIRTH NO.

RECEIVED
NOV 10 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 1/2 mi. NE of City 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Sandra	June	Harper	Nov. 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	never married	Nov. 8, 1952	14	11	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
student 03	school	Emmett, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wayne F. Harper	New Plymouth, Ida	Evelyn Bieber	Big Timber, Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-64-7146	X Wayne F Harper	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Fracture of Skull — Immediate
DUE TO (c) Auto accident.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
ACCIDENT	Rural Road	Emmett Gem Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Nov 6 1967 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	Auto accident.

22. *I hereby certify that I attended the deceased from* 11-8, 19 52, *to* 11-6, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 5 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	429 (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ronald P. Lewerenz		108 W 2nd S Emmett	11/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov. 9, 1967	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 8, 1967	Glenn A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 9 1968

JAN 11 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 15 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5005
Local Reg. No. 34
Reg. Dist. No.

RECEIVED NOV 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 231 3-64
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Memorial Hosp. 035

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 231 Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location) Box 444, 109 West Main

3. NAME OF DECEASED (Type or Print) a. (First) Bertie b. (Middle) c. (Last) Wood

4. DATE OF DEATH (Month) (Day) (Year) Nov. 7, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Sept. 27, 1895

9. AGE (In years last birthday) 72
IF UNDER 1 YEAR Months 0 Days 10
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY home

11. BIRTHPLACE (State or foreign country) Hickory, No. Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Daniel Reinhardt
BIRTHPLACE N. C.

14. MOTHER'S MAIDEN NAME Eliza Rhodes
BIRTHPLACE N. C.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-12-3350A

17. INFORMANT'S OWN SIGNATURE X Joan A. Sorenson ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-11 *,* 1967 *, to* 11-7 *,* 19 67 *, that I last saw the deceased alive on* 11-7 *,* 1967 *, and that death occurred at* 8:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Joanna E. Halverson 241 (Degree or title) M.D.

23b. ADDRESS Emmett, Idaho

23c. DATE SIGNED 11-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 10, 1967

24c. NAME OF CEMETERY OR CREMATORY Emmett

24d. LOCATION (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. Nov 9 1967

REGISTRAR'S SIGNATURE Joan A. Beatty

25. EMBALMER Thurman W Beatty

LICENSE NO. E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 16 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5006
Local Reg. No. 35
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231 000
b. CITY OR TOWN (If outside corporate limits, give RURAL and give township): Emmett
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 210 East 2nd 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 231 Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 210 East 2nd

3. NAME OF DECEASED (Type or Print)
a. (First): Gerald
b. (Middle): Park
c. (Last): Gill

4. DATE OF DEATH (Month) (Day) (Year): Nov. 13, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Nov. 15, 1919

9. AGE (In years last birthday): 47
IF UNDER 1 YEAR: Months 11 Days 28
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): doctor 14

10b. KIND OF BUSINESS OR INDUSTRY: dentistry

11. BIRTHPLACE (State or foreign country): Rexburg, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Peter Park
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Mary
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WWII 4

16. SOCIAL SECURITY NO.: 518-18-1763

17. INFORMANT'S OWN SIGNATURE: X Bettye J. Gill
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): gunshot into head — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Emmett 13 Gem 231 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 13, 1967 11:25 p.m. 2
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Shot self in head

22. *I hereby certify that I attended the deceased from* never, 19____, *to* _____, 19____, *that I last saw the deceased alive on* never, 19____, *and that death occurred at* 11:25 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Glenn W Beatty 583
(Degree or title): Coroner Gem County
23b. ADDRESS: Emmett, Idaho
23c. DATE SIGNED: Nov. 14, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial 1
24b. DATE: Nov. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Nov. 14, 1967
REGISTRAR'S SIGNATURE: Jean A Beatty
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 30 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 6 1967

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

SEP 17 1968

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

JAN 9 1978

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

NOV -1 1985

Special attention should be given to the satisfactory completion of EACH portion of [illegible] item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

R.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5007
Local Reg. No. 36
Reg. Dist. No. 240-241

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 30 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Shady Lane Nursing Home 265

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 231 Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): 516 So. DeClark

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Rebecca	Nancy	Snell	Nov. 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	Oct. 9, 1884	83	1	13		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Union Co., Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Luther Lloyd — BIRTHPLACE: Fayette, Missouri
14. MOTHER'S MAIDEN NAME: May Tarter — BIRTHPLACE: Otoe Co., Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 542-18-1884A
17. INFORMANT'S OWN SIGNATURE: X Vera L. Garrett — ADDRESS: Horseshoe Bend

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Terminal Pneumonia following	4 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Hypostatic Congestion	2 months
DUE TO (c)	Cancer of Large Bowel	2 years
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Senile Cerebral Psychosis	

1538

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 1962, to Nov 22, 1967, *that I last saw the deceased alive* Nov 22, 1967, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald P. Lawless 429	MD	Emmett Ida	11/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov. 25, 1967	Pioneer	Horseshoe Bend, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov 30, 1967	Jean A Beatty	Walter Potter	E-445

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5008
Local Reg. No. 37
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Gem 231 DEC 7 1967
b. CITY OR TOWN Emmett
c. LENGTH OF STAY (in this place) 14mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shady Lane Nursing Home 265

Bureau of Vital Statistics 1-01

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Inez
b. (Middle) Lisby
c. (Last) Bibb

4. DATE OF DEATH (Month) (Day) (Year) Nov. 26, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3

8. DATE OF BIRTH April 17, 1882

9. AGE (In years last birthday) 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY home

11. BIRTHPLACE (State or foreign country) Etna, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William F. Shawley
BIRTHPLACE Kentucky

14. MOTHER'S MAIDEN NAME Mary Ann Sayers
BIRTHPLACE Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 534 07 1888B

17. INFORMANT'S OWN SIGNATURE Harold M Pomeroy
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-26, 1967, *to* 11-26, 19 67, *that I last saw the deceased alive on* ------, 19____, *and that death occurred at* 10:15 P. M., *from the causes and on the date stated above.*

23a. SIGNATURE Harmon E. Halverson M.D. 241 (Degree or title)

23b. ADDRESS Emmett, Idaho

23c. DATE SIGNED 12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Nov. 29, 1967

24c. NAME OF CEMETERY OR CREMATORY Emmett

24d. LOCATION (City, town, or county) Emmett, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 5 1967

REGISTRAR'S SIGNATURE Grant A Beatty

25. EMBALMER Glenn W Beatty

LICENSE NO. E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 6 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 9 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5009
Local Reg. No. 38
Reg. Dist. No. 340 341

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 5 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Gem 231 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem 231
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
d. STREET ADDRESS (If rural, give location): Route 1 Box 317

3. NAME OF DECEASED (Type or Print)
a. (First): William
b. (Middle): George
c. (Last): Chilcott

4. DATE OF DEATH (Month) (Day) (Year): November 27, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: April 9, 1883
9. AGE (In years last birthday): 84 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: ranch
11. BIRTHPLACE (State or foreign country): Pittsburg, Penn.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Chilcott — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Elizabeth Cooper — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 42 6383 A
17. INFORMANT'S OWN SIGNATURE: X Robert D. Chilcott — ADDRESS: Box 94, Wells, Nev.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5705

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Int. obstruction — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): c Haemorrhage from bowell
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.: Pulmonary emphysema & fibrosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 1965, to _____, 1967, that I last saw the deceased alive on 27 Nov., 1967, and that death occurred at 4:30 p. m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 184 mo!
23b. ADDRESS: Emmett, Ida.
23c. DATE SIGNED: 29 Nov. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Dec 1, 1967
REGISTRAR'S SIGNATURE: Jean A. Beatty
25. EMBALMER: Glenn W. Beatty
LICENSE NO.: E392

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: The Beatty Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5010
Local Reg. No. 3011
Reg. Dist. No. 420

Certificate of Death

RECEIVED DEC 5 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 240
a. COUNTY Gooding 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wendell
c. LENGTH OF [illegible] (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 070 Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hailey
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) RHODA
b. (Middle) FRANCES
c. (Last) POULSON

4. DATE OF DEATH (Month) (Day) (Year) Nov. 7, 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH March 16, 1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Goshen, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles White — BIRTHPLACE —
14. MOTHER'S MAIDEN NAME Matilda Guymon Foutain — BIRTHPLACE Green, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 519-18-7754
17. INFORMANT'S OWN SIGNATURE x Nellie Peterson — ADDRESS Hailey, Idaho

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ant. sclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 17 1964, *to* Nov., 1967, *that I last saw the deceased alive on* 11-5, 1967, *and that death occurred at* — *m., from the causes and on the date stated above.*

23a. SIGNATURE 4578 Maurice E. Scheel (Degree or title) MD
23b. ADDRESS Wendell Ida
23c. DATE SIGNED 11-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE 11/6/67
24c. NAME OF CEMETERY OR CREMATORY Hailey Cemetery
24d. LOCATION (City, town, or county) (State) Hailey, Idaho

DATE REC'D BY LOCAL REG. Nov. 30, 1967
REGISTRAR'S SIGNATURE Robert S. Meyer
25. EMBALMER Keith Bird — Keith Bird
LICENSE NO. E- 373

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bird Funeral Home, Hailey

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5011
Local Reg. No. 3012
Reg. Dist. No. 420

BIRTH NO.

RECEIVED DEC 22 1967 BUREAU OF V

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gooding 240 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magie Valley Manor 253

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 070 Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bellevue
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Mary	E.	Thompson	Nov. 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	July 9, 1878	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	—	Boise, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Hurst	Oregon	Nancy Jane Cowsert	Misouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	—	Lamont Thompson	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Old age and Inanition	6 mo
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Numular Eczema	2 yrs.
DUE TO (c)	Diaphragmatic Hernia	6 mo.
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Osteoarthritis	5 yrs.
	Osteoporosis	5 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-2, 1966, *to* death, 19—, *that I last saw the deceased alive on* Oct 29, 1967, *and that death occurred at* 7:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
240 Harold G. Holsinger MD	Wendell Ida	12/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 4, 67	Picabo Cemetery	Picabo, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 9, 1967	Robert E. Meyer	Keith Bird Keith Bird	E-373

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bird Funeral Home

DUTIES: DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5012
Local Reg. No. 16
Reg. Dist. No. 242

Certificate of Death

RECEIVED
DEC 1 1 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (in this place): 13 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sr. M. Alphonsa
b. (Middle): (Catherine Agnes Sweeney)
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): Nov 1 67

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: Oct 8 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: religious
11. BIRTHPLACE (State or foreign country): Napa, California
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Dennis Sweeney — BIRTHPLACE: Ireland
14. MOTHER'S MAIDEN NAME: Mary Lucey — BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 60 7425
17. INFORMANT'S OWN SIGNATURE: Sister Mary Agatha, OSB — ADDRESS: Cottonwood

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: 11 mos

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): A.S.H.D. — 7 yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Pneumonitis with Pleural Effusion in Generalized cerebral degeneration — Jan., 1967

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 22, 1966, *to* Nov. 1, 1967, *that I last saw the deceased alive on* Nov. 1, 1967, *and that death occurred at* 2:55 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 399 ~~co. F. Orr, MD~~ 1
23b. ADDRESS: Cottonwood, Idaho
23c. DATE SIGNED: 11-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Nov 4 67
24c. NAME OF CEMETERY OR CREMATORY: St. Gertrudes
24d. LOCATION (City, town, or county) (State): Cottonwood, Idaho

DATE REC'D BY LOCAL REG.: Nov. 3, 1967
REGISTRAR'S SIGNATURE: Wesley F. Orr M.D.
25. EMBALMER: Clifford Uhlorn
LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5013
Local Reg. No. 69
Reg. Dist. No. 340

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Idaho 250 — NOV 2 0 1967 — 000
b. CITY OR TOWN: Elk City — Bureau of Vital Statistics — c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION: 9 miles E. of Fall Creek Hiway 14 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
d. STREET ADDRESS (If rural, give location): East Kamiah

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Ira	David	Penney	November 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Negro or Ind	married 3	August 1, 1911	56		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Woodsman 17	Logging	Webb Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
David Penney	Idaho	Susie Unk	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WWII 4	518-01-4100	Pauline Samuels	Kamiah, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Drowning	unknown
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Car accident - into river	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Ethanolism (Blood alcohol 0.28%)	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT (Specify) SUICIDE HOMICIDE	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
Car accident 1	Elk City Road 06	13 Elk City	Idaho 250	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Nov 3 m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☑	Car ran off road into river

22. *I hereby certify that I attended the deceased from* None, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Altman M.D 487	Orangeville, Idaho	14 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial 1	Nov. 7, 1967	Presbyterian 1st church	Kamiah	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 16, 1967	Irma Cone	Robert H. Hansen	E 433

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5014
Local Reg. No. 78
Reg. Dist. No. 240

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
DURATION OF STAY (in this place): ½ hr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riggins
d. STREET ADDRESS (If rural, give location): Riggins, Idaho

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
MORLEY	WILLIAM	HOPPER	November 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	December 5, 1910	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Various	Midvale, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ernest Hopper	Midvale	Margaret Johns	Fairview, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 10 8896	x Nila O Hopper	Riggins, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immed

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary atherosclerosis & angina — several mos.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased* ~~from~~ on 4 Nov, 19 67, to _____, 19____, *that I last saw the deceased alive on* 4 Nov, 19 67, *and that death occurred at* 2:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Altman	4/87 M.D.	Grangeville, Idaho	14 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 8, 1967	Prairieview	Grangeville, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 18 1967	Irma Cone	Robert R Hansen Robert R Hansen	E433

FIRM NAME: Robertson-Hansen funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5015
Local Reg. No. 67
Reg. Dist. No. 240

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250 | LENGTH OF STAY: 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Hill Manor 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia
d. STREET ADDRESS (If rural, give location): Tahoe Ridge

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Allen	Burris	York	Nov.	6	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	white	Widowed 2	March 3, 1903	64		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ranch owner 04	Cattle	Clearwater Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Rev. J.B. York	Tenn.	Martha Allen	Georgia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-42-2976	Ruth York	Kooskia Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Lung — INTERVAL BETWEEN ONSET AND DEATH: 9 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Metastatic anaplastic Carcinoma of Lung	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1, 1967, *to* Nov 6, 1967, *that I last saw the deceased alive on* Nov 5, 1967, *and that death occurred at* 9:40 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
373 Wm Morrison MD.	Grangeville, Id.	Nov 10, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 9 1967	Pine Grove Cem.	Kooskia Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 13, 1967	Irma Cone	Robert R Hansen	E433

FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5016
Local Reg. No. 72
Reg. Dist. No. 240

RECEIVED NOV 27 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) rural Riggins
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) So. Rapid River Bridge 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pollock
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) c. (Last) WINKLER

4. DATE OF DEATH (Month) (Day) (Year) November 9, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married 1
8. DATE OF BIRTH April 8, 1902
9. AGE (In years last birthday) 65 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Butcher & Laborer 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Council, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George M. Winkler BIRTHPLACE W. Virginia
14. MOTHER'S MAIDEN NAME Elizabeth Harp BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W W 2 4
16. SOCIAL SECURITY NO. 519-01-8365
17. INFORMANT'S OWN SIGNATURE Personal papers ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Auto Accident Injuries

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway #95 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 Pollock (COUNTY) Idaho 250 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 0
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR? Auto Accident

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 583 (Degree or title) 4 Cornel Montell Act. Corporal
23b. ADDRESS Box 32 Grangeville, Ida.
23c. DATE SIGNED 11/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE Nov. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY I O O F Cemetery
24d. LOCATION (City, town, or county) Council. (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 22, 1967
REGISTRAR'S SIGNATURE Irma Cone
25. EMBALMER Cletus Uhlorn
LICENSE NO. E 42

FIRM NAME: Robertson-Hansen Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 28 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5017
Local Reg. No. 71
Reg. Dist. No. 240

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 250 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville -9 mi East
c. LENGTH OF STAY (in this place): —
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Earthquake basin-Blacktail Butte 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kooskia
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Milo
b. (Middle): Virgil
c. (Last): Weisbeck

4. DATE OF DEATH (Month) (Day) (Year): November 14, 1967

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Dec. 7, 1938
9. AGE (In years last birthday): 28 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Woodsman 17
10b. KIND OF BUSINESS OR INDUSTRY: Logging
11. BIRTHPLACE (State or foreign country): Wallace Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Weisbeck — BIRTHPLACE: Clear Lake Wisc.
14. MOTHER'S MAIDEN NAME: Mable Helland — BIRTHPLACE: Fillmore Co. Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 7 1958 - 1962
16. SOCIAL SECURITY NO.: 518-40-8076
17. INFORMANT'S OWN SIGNATURE: Mabel Weisbeck — ADDRESS: Kooskia, Idaho

9368

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushing injuries to chest + spine

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ~~ACCIDENT~~ SUICIDE HOMICIDE (Specify): Forrest E. of Gr-V. Ida
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 09
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 250 (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 14, 67, 4 P.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: logging acc.

22. *I hereby certify that I attended the deceased from* never treated by me *19__, to* 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 4 P.M. *m., from the causes and on the date stated above.*

23a. SIGNATURE 621 (Degree or title): Milton H. Wiltse, Ph.D.
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 20 Nov. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 18 1967
24c. NAME OF CEMETERY ~~OR CREMATORY~~: Pine Grove
24d. LOCATION (City, town, or county): Kooskia (State): Idaho

DATE REC'D BY LOCAL REG.: Nov. 21, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R. Hansen
LICENSE NO.: E433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Trenary Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5018
Local Reg. No. 75
Reg. Dist. No. 24D

Certificate of Death

RECE[illegible] STATE OF IDAHO

BIRTH NO.

DEC 19 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 2 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho County Nursing Home 276

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 301 North Florence

3. NAME OF DECEASED (Type or Print)
a. (First): MINNIE
b. (Middle): DECATUR
c. (Last): MOORE

4. DATE OF DEATH (Month) (Day) (Year): November 28, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: February 5, 1878
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Malad, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Stanton Fisher — BIRTHPLACE: Chaumont, N. Y.
14. MOTHER'S MAIDEN NAME: Sarah A. Peck — BIRTHPLACE: Greene County, N. Y.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 42 0562
17. INFORMANT'S OWN SIGNATURE: Alfred J. Moore — ADDRESS: R. 2 Grangeville

18. CAUSE OF DEATH 4500
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: Several days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): generalized arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fracture, left hip — 8 weeks.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 Oct, 1967, *to* 28 Nov, 1967, *that I last saw the deceased alive on* 27 Nov, 1967, *and that death occurred at* 7:55A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald J. Saltman M.D. 487
23b. ADDRESS: Grangeville, Idaho
23c. DATE SIGNED: 5 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 11/30/67
24c. NAME OF CEMETERY OR CREMATORY: Prairieview
24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Dec. 15, 1967
REGISTRAR'S SIGNATURE: Irma Cone
25. EMBALMER: Robert R. Hansen
LICENSE NO.: E433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robertson - Hansen

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5019
Local Reg. No. 73
Reg. Dist. No. 240

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
DEC 18 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Idaho 250 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville,
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Grangeville, General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) 092 402 North Mill St.

3. NAME OF DECEASED (Type or Print)
a. (First) JANIE
b. (Middle) A.
c. (Last) HANSEN

4. DATE OF DEATH (Month) (Day) (Year) November 29, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH August 25, 1901
9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Bolton, England
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles McHugh — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Louisa Jones — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 44 2581
17. INFORMANT'S OWN SIGNATURE X William Shillam — ADDRESS Pierce, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Coronary Insufficiency
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes, CHF

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1966, *to* 29 Nov., 1967, *that I last saw the deceased alive on* 29 Nov., 1967, *and that death occurred at* 7:35 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE Milton H. Wiltse, M.D. 621 (Degree or title)
23b. ADDRESS Grangeville, Idaho
23c. DATE SIGNED 6 Dec., 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY Prairieview Cemetery
24d. LOCATION (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. Dec. 12, 1967
REGISTRAR'S SIGNATURE Irma Cone
25. EMBALMER Robert R Hansen
LICENSE NO. E433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robertson-Hansen Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5020
Local Reg. No. 74
Reg. Dist. No. 240

BIRTH NO.

RECEIVED DEC 19 1967

1. PLACE OF DEATH
a. COUNTY: Idaho 250 1-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 710 Elk Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): 710 Elk Street

3. NAME OF DECEASED (Type or Print): a. (First) PETER b. (Middle) WINFRED c. (Last) SARBACHER

4. DATE OF DEATH (Month) (Day) (Year): November 30 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 5, 1901	66				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Perham, Minnesota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Sarbacher	Marion County Ohio	Mary Fry	Baden Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518 20 6403	X Mrs Pete Sarbacher	Grangeville, Ida

1810

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Carcinoma of the bladder — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Carcinoma of the prostate 2 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—		—

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
— m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	—

22. *I hereby certify that I attended the deceased from* Oct. 6, 1967, *to* Nov 30, 1967, *that I last saw the deceased alive on* Nov. 29, 1967 *and that death occurred at* 12 pm. *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 487	MD	Grangeville, Idaho	12/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 2, 1967	Ferdinand	Ferdinand, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 15, 1967	Irma Cone	Robert R Hansen [signature]	E 433

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robertson-Hansen Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5021
Local Reg. No. 15
Reg. Dist. No. 640

RECEIVED NOV 21 1967 5-05

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jefferson 260
b. CITY OR TOWN Roberts (rural) Bureau of
c. LENGTH OF STAY (in this place) Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION 2 mi. South of Roberts 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jefferson 260
c. CITY OR TOWN Roberts
d. STREET ADDRESS (If rural, give location) 120 Milwaukee Ave.

3. NAME OF DECEASED (Type or Print) a. (First) RALPH b. (Middle) JOSEPH c. (Last) MASSENGALE

4. DATE OF DEATH (Month) (Day) (Year) Nov. 4, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 30, 1924
9. AGE (In years last birthday) 43 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Farm
11. BIRTHPLACE (State or foreign country) Silver City, South Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Massengale BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Jennie Pearl Osborne BIRTHPLACE So. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WWII 4
16. SOCIAL SECURITY NO. 519-34-0227
17. INFORMANT'S OWN SIGNATURE Harold F. Massengale ADDRESS Astoria, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chest and Head Injuries — INTERVAL BETWEEN ONSET AND DEATH Inst.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile accident
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Roberts (rural) 13 Jefferson 260 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov. 4, 1967 11:15 PM 2
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Automobile collision.

22. I hereby certify that I attended the deceased from [illegible] death occurred at 11:15 P.M., from the causes and on the date stated above.

23a. SIGNATURE Norman Hall 583 (Degree or title) coroner 4
23b. ADDRESS Rigby, Idaho.
23c. DATE SIGNED 6 NOV 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY Annis Little Butte
24d. LOCATION (City, town, or county) (State) Annis Jefferson Idaho.

DATE REC'D BY LOCAL REG. Nov 6 1967
REGISTRAR'S SIGNATURE Mrs A B Eckersell
25. EMBALMER Bruce A. Eckersell LICENSE NO. E-404
FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5022
Local Reg. No. 16
Reg. Dist. No. 640

RECEIVED
NOV 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260 1-30
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Menan (rural)
LENGTH OF STAY (In this place): 30 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1 1/2 Mi. S.E. of Menan

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 260 Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Menan (rural)
d. STREET ADDRESS (If rural, give location): 1 1/2 Mi. S.E. of Menan

3. NAME OF DECEASED (Type or Print): a. (First) DORBUARY b. (Middle) JANE c. (Last) WINDER

4. DATE OF DEATH (Month) (Day) (Year): Nov. 7, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: May 8, 1891

9. AGE (In years last birthday): 76
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Wellington, Utah.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Eot Wilson — BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Mary Jane Leek — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-60-2115

17. INFORMANT'S OWN SIGNATURE: Dorbuary J Winder — ADDRESS: Long Beach, Cal.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cardio Vascular Heart disease — 5 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes Mellitis — ?

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 19, 1954 *to* October 27, 1967, *that I last saw the deceased alive on* October 27, 1967, *and that death occurred at* 11:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Clifford B. Rigby M.D. — **23b. ADDRESS**: Rigby — **23c. DATE SIGNED**: 11-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: Nov. 11, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Grant Central — **24d. LOCATION** (City, town, or county) (State): Grant Bonneville Idaho

DATE REC'D BY LOCAL REG.: Nov 10 1967 — REGISTRAR'S SIGNATURE: Mrs A B Eckersell

25. EMBALMER: Bruce A. Eckersell — LICENSE NO.: E-404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5023
Local Reg. No. 1044
Reg. Dist. No. 440

Certificate of Death

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome (rural) 83338
d. STREET ADDRESS (If rural, give location): Rt. 2 Box 58

3. NAME OF DECEASED (Type or Print)
a. (First): EUGENE
b. (Middle): TONY
c. (Last): MEYER

4. DATE OF DEATH (Month) (Day) (Year): Nov. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: June 30, 1958
9. AGE (In years last birthday): 9 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Grade School
11. BIRTHPLACE (State or foreign country): Spokane, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Herbert W. Meyer — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Mary C. Hankins — BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: x Herbert W. Meyer — ADDRESS: Jerome, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9190

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Abdominal shotgun wound — INTERVAL BETWEEN ONSET AND DEATH: 14 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) reportedly accidental self-inflicted shotgun blast.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: Nov. 9, 1967
19b. MAJOR FINDINGS OF OPERATION: Gunshot wounds, transected stomach, rt. colon, lacerated rt. kidney,
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT (Specify) ~~SUICIDE~~ ~~HOMICIDE~~ as far as known
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP): 13 Jerome, — (COUNTY): 270 Jerome — (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 9, 1967 5:30 PM
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR?: Accidental self-inflicted

22. *I hereby certify that I attended the deceased from* Nov. 9, 1967, *to* Nov. 10, 1967, *that I last saw the deceased alive on* Nov. 10, 1967, *and that death occurred at* 8:20A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Jon D. Wilmoth 770 — (Degree or title): M. D.
23b. ADDRESS: 216 East Main Jerome, Ida.
23c. DATE SIGNED: 11/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: Nov. 16, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5024
Local Reg. No. 1045
Reg. Dist. No. 440

BIRTH NO.

NOV 20 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Benedict's Hospital 077

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome (rural) 83338
d. STREET ADDRESS (If rural, give location) Rt. # 2 Box 6

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARY	KATHRYN	NUTSCH	Nov. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Oct. 20, 1897	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	at home	Thompson, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Huber	Ontario, Canada	Katherine Deger	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 44 2493A	X Edwin C. Nutsch	Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

2044

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Leukemia — INTERVAL BETWEEN ONSET AND DEATH: About 12 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
None		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1945, 19___, *to* 11/9/67, 19___, *that I last saw the deceased alive on* 11/9/67, 19___, *and that death occurred at* 10:28A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
N. Conyle Braid 477	MD	Jerome, Idaho	11/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 14, 1967	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 16 1967	Lowella M. Scherer	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5025
Local Reg. No. 1046
Reg. Dist. No. 440

RECEIVED
NOV 20 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 305 East Ave. "A"

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle): 099 ALEXANDER
c. (Last): GILLESPIE

4. DATE OF DEATH (Month) (Day) (Year): Nov. 13, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 14, 1873
9. AGE (In years last birthday): 94 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Real Estate Agt.
10b. KIND OF BUSINESS OR INDUSTRY: 24
11. BIRTHPLACE (State or foreign country): Albany, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John F. Gillespie — BIRTHPLACE: not known
14. MOTHER'S MAIDEN NAME: Mary ----- — BIRTHPLACE: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 40 1201
17. INFORMANT'S OWN SIGNATURE: X Margaret Noedel — ADDRESS: Jerome, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Inanition - gen debility — INTERVAL BETWEEN ONSET AND DEATH: 2 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Senility — yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1958, *to* 13 Nov, 1967, *that I last saw the deceased alive on* 9 Nov, 1967, *and that death occurred at* 5:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 385 — L. M. Scherer, M.D.
23b. ADDRESS: Jerome
23c. DATE SIGNED: 13 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Nov. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Grandview Cemetery
24d. LOCATION (City, town, or county) (State): Albany, Missouri 64402

DATE REC'D BY LOCAL REG.: Nov. 16, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 18 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5026
Local Reg. No. 1048
Reg. Dist. No. 440

RECEIVED NOV 29 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270 1-17
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY IN THIS PLACE (In this place): 17 years

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome, Route 2, 83338

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Hospital 099
d. STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print): a. (First) IVA b. (Middle) NATION c. (Last) LYONS

4. DATE OF DEATH (Month) (Day) (Year): November 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	August 18, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Huntley, Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Douglas Nation		Deborah Powell	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	---	523-10-5867D	X Ralph Lyons	Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION — 33 1X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) essential hypertension
DUE TO (c) art. sclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-14- , 19 64, *to* 11-15- , 19 67, *that I last saw the deceased alive on* 11-14- , 19 67, *and that death occurred at* 7:05 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
457 Maurice E. Schell MD	Wendell, Idaho 83355	11/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial 1	Nov. 18, 1967	Sunset Memorial Park	Twin Falls 83301 Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 28 1967	Louella M. Dekker	Russell D. Mikel	E-520

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: WHITE MORTUARY 733-6600

NOV 30 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5027
Local Reg. No. 1049
Reg. Dist. No. 440

BIRTH NO.

RECEIVED

STATE OF IDAHO

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270 — DEC 7 1967 — 3-10
b. CITY OR TOWN: Jerome 83338
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 420
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly 83341
d. STREET ADDRESS (If rural, give location): 431 Jackson St. West

3. NAME OF DECEASED (Type or Print): a. (First) JAMES — b. (Middle) HARVEY — c. (Last) MCDRUMMOND

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 23, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: April 16, 1900

9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): buyer 06

10b. KIND OF BUSINESS OR INDUSTRY: produce

11. BIRTHPLACE (State or foreign country): Oklahoma

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clark McDrummond — BIRTHPLACE: Tennessee

14. MOTHER'S MAIDEN NAME: Eva. Young — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.: 519-05-8251

17. INFORMANT'S OWN SIGNATURE: x Pearl McDrummond — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8230

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Multiple injuries from traffic accident

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): including crushed L. chest

DUE TO (c): & fracture of femur -

INTERVAL BETWEEN ONSET AND DEATH: 10 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway - 06

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 270 Jerome Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11 13 67 5:50 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?: Pickup truck rolled.

22. *I hereby certify that I attended the deceased from* 13 Nov *, 1967, to* 23 Nov *, 1967, that I last saw the deceased alive on* 23 Nov *, 1967, and that death occurred at* 9:10a *m., from the causes and on the date stated above.*

23a. SIGNATURE: R. Tucker M.D. 583 — (Degree or title): Coroner

23b. ADDRESS: Jerome

23c. DATE SIGNED: 27 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 11-25-67

24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.: Dec. 1, 1967

REGISTRAR'S SIGNATURE: Louella M. Deherrera

25. EMBALMER: Dale P. Patterson — LICENSE NO.: E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 19 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5028
Local Reg. No. 1046
Reg. Dist. No. 440

RECEIVED NOV 28 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 508 3rd. Ave. West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) 508 3rd. Ave. West

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) WILLIAM
c. (Last) SEXTON

4. DATE OF DEATH (Month) (Day) (Year) Nov. 24, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan. 31, 1890
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Fulton Co., Arkansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William S. Sexton — BIRTHPLACE Arkansas
14. MOTHER'S MAIDEN NAME Matilda Hightower — BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 34 3209
17. INFORMANT'S OWN SIGNATURE X Mrs. Mary Bell Sexton — ADDRESS Jerome, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 30 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 2, 1967, *to* Nov. 24, 1967, *that I last saw the deceased alive on* Nov. 24, 1967, *and that death occurred at* 9:40P *m., from the causes and on the date stated above.*

23a. SIGNATURE Jon D. Wilmoth, M.D. 770 (Degree or title)
23b. ADDRESS 216 E. Main; Jerome, Ida
23c. DATE SIGNED 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. Nov. 27, 1967
REGISTRAR'S SIGNATURE Louella M. Deherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5029
Local Reg. No. 1047
Reg. Dist. No. 440

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 000
b. CITY OR TOWN Jerome
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 320 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shoshone (rural) 83352
d. STREET ADDRESS (If rural, give location) Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPHINE
b. (Middle)
c. (Last) VELASQUEZ

4. DATE OF DEATH (Month) (Day) (Year) Nov. 24, 1967

5. SEX Female

6. COLOR OR RACE Mexican

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH June 22, 1891

9. AGE (In years last birthday) 76
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY at home

11. BIRTHPLACE (State or foreign country) Canjilon, New Mexico

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jose Gallegos
BIRTHPLACE New Mexico

14. MOTHER'S MAIDEN NAME Maria I. Baca
BIRTHPLACE New Mexico

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 18 1572

17. INFORMANT'S OWN SIGNATURE Wilbur S. Hove
ADDRESS Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arterio Sclerotic Cardio-vascular renal disease — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4427

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 12, 1965, *to* November 24, 1967, *that I last saw the deceased alive on* November 23, 1967, *and that death occurred at* 5:10 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 386 (Degree or title)

23b. ADDRESS Box 68 Shoshone Ida 83352

23c. DATE SIGNED 11-25-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 27, 1967

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) (State) Rupert, Idaho 83350

DATE REC'D BY LOCAL REG. Nov. 27 1967

REGISTRAR'S SIGNATURE Louella M. Scherer

25. EMBALMER W. L. Hove

LICENSE NO. E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5030
Local Reg. No. 1050
Reg. Dist. No. 440

BIRTH NO.

RECEIVED

STATE OF IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Jerome 270 DEC 7 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 321 West Ave. "E" 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 321 West Ave. "E"

3. NAME OF DECEASED (Type or Print) a. (First) CARL b. (Middle) JOHN c. (Last) JOHNSON

4. DATE OF DEATH (Month) (Day) (Year) Nov. 29, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 15, 1894

9. AGE (In years last birthday) 73 | If UNDER 1 YEAR Months Days | If UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Laborer 08

10b. KIND OF BUSINESS OR INDUSTRY City Water Dept.

11. BIRTHPLACE (State or foreign country) Oberlin, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lars Johnson | BIRTHPLACE Sweden

14. MOTHER'S MAIDEN NAME Eliza B. Wickland | BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 536 12 6905

17. INFORMANT'S OWN SIGNATURE Lorena Johnson | ADDRESS Jerome, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9030

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage Brain | INTERVAL BETWEEN ONSET AND DEATH 0

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident | 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home (Yes) | 21c. (CITY, TOWN, OR TOWNSHIP) 13 Jerome | (COUNTY) 270 Jerome | (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 29 67 5:30 p.m. | 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 0, 19 0, to Nov 29, 1967, that I last saw the deceased alive on Nov 29, 1967, and that death occurred at 5:30P m., from the causes and on the date stated above.

23a. SIGNATURE J. E. Hove 476 (Degree or title) MD-1 | 23b. ADDRESS Jerome Idaho | 23c. DATE SIGNED 12/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 24b. DATE Dec. 2, 1967 | 24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery | 24d. LOCATION (City, town, or county) Jerome, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 5, 1967 | REGISTRAR'S SIGNATURE Louella M. Schurer

25. EMBALMER W. L. Hove | LICENSE NO. E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5031
Local Reg. No. 1051
Reg. Dist. No. 440

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 7 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
d. STREET ADDRESS (If rural, give location): 421 East Main

3. NAME OF DECEASED (Type or Print)
a. (First): FRANK
b. (Middle):
c. (Last): THOMAS

4. DATE OF DEATH (Month) (Day) (Year): Nov. 30, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Aug. 11, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Livestock Dealer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Prarie View, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Daniel W. Thomas — BIRTHPLACE: not known
14. MOTHER'S MAIDEN NAME: Mary Sparks — BIRTHPLACE: not known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 36 9158
17. INFORMANT'S OWN SIGNATURE: X Dale A. Thomas — ADDRESS: Jerome, Ida.

7055

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Senility (84 yrs old) — INTERVAL BETWEEN ONSET AND DEATH: —

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Mildly infected wound from dip surgery — 5 weeks
DUE TO (c): Exfoliative dermatitis — 4 mo.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: —

19a. DATE OF OPERATION: 10/14/67
19b. MAJOR FINDINGS OF OPERATION: Fracture of rt hip
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 1940, 19__, *to* _____, 19__, *that I last saw the deceased alive on* 11/30/67, 19__, *and that death occurred at* 1:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. Carlyle Brisil 477 (Degree or title): MD
23b. ADDRESS: Jerome Idaho
23c. DATE SIGNED: 12/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: Dec. 5, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED DEC 7 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5032
Local Reg. No. 1052
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN: Jerome 83338
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 421 Twin Falls
c. CITY OR TOWN: Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 254 Lois St.

3. NAME OF DECEASED (Type or Print): a. (First) Robert b. (Middle) Emmett c. (Last) Howard

4. DATE OF DEATH (Month) (Day) (Year): November 30, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 26, 1890
9. AGE (In years last birthday): 77 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 28
10b. KIND OF BUSINESS OR INDUSTRY: invalid
11. BIRTHPLACE (State or foreign country): Lawson, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Michael Howard BIRTHPLACE: Ireland
14. MOTHER'S MAIDEN NAME: Ann Courtney BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-68-3575 J1
17. INFORMANT'S OWN SIGNATURE: X Hazel A. Howard ADDRESS: Rogerson, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1530

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia, broncho - left — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Atelectasis of the right lung — 4 days.

19a. DATE OF OPERATION: Nov. 26, 1967
19b. MAJOR FINDINGS OF OPERATION: Complete bowel obstruction at ileocecal area by adhesions
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 2, 19 67, *to* Nov. 30, 19 67, *that I last saw the deceased alive on* Nov. 30, 19 67 *and that death occurred at* 9:05a m., *from the causes and on the date stated above.*

23a. SIGNATURE: Jon D. Wilcoxsk, M.D. 770 (Degree or title)
23b. ADDRESS: 216 East Main St.; Jerome Ida.
23c. DATE SIGNED: Dec. 1, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 6, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: Russell D. Mikel
LICENSE NO.: E-520
FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
NOV 6 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5033
Local Reg. No. 216
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 100
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 501-1st St. Apt. 91 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 501-1st St. Apt. 91

3. NAME OF DECEASED (Type or Print)
a. (First) Ethel
b. (Middle) Chloe
c. (Last) Chaffins

4. DATE OF DEATH (Month) (Day) (Year) Nov. 1, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 9, 1892
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own HOme
11. BIRTHPLACE (State or foreign country) Bellville, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME L.W. Bonner — BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Bertha Phillips — BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-34-5054B
17. INFORMANT'S OWN SIGNATURE Frank M Chaffins — ADDRESS Coeur d'Alene Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

156 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH weeks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10.15.67
19b. MAJOR FINDINGS OF OPERATION Extensive Carcinoma of liver & omentum c̄ obstruction of colon
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10 14, 1967, *to* 10.25, 1967, *that I last saw the deceased alive on* 10.25, 1967, *and that death occurred at* 11:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Clifford H. Lyon, Jr. 313 (Degree or title) M.D.
23b. ADDRESS 411 Coeur d'Alene Ave. Idaho CDA
23c. DATE SIGNED 11.2.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-4-1967
24c. NAME OF CEMETERY OR CREMATORY St Thomas Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. 11-6-67
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER Bill Duff — LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

DUTIES:

DEC 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 17 1985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Fox

Certificate of Death

RECEIVED NOV 6 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 5034
Local Reg. No. 218
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 3-14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Ethel
b. (Middle) H. 101
c. (Last) Ferger

4. DATE OF DEATH (Month) Nov. (Day) 1 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH May 21, 1907
9. AGE (In years last birthday) 60 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Mace, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Axel Lillquist — BIRTHPLACE Finland
14. MOTHER'S MAIDEN NAME Hannah — BIRTHPLACE Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Wm Ferger, Post Falls, Idaho — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of Breast c̄ 170X — INTERVAL BETWEEN ONSET AND DEATH 1 yr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) metastases
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/8, 1967, *to* 11/1, 1967, *that I last saw the deceased alive on* 11/1, 1967 *and that death occurred at* 1:50 p *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 174 (Degree or title) M.D.
23b. ADDRESS Coeur d'Alene
23c. DATE SIGNED 11/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-4-1967
24c. NAME OF CEMETERY OR CREMATORY Evergreen Cem.
24d. LOCATION (City, town, or county) Post Falls, (State) Ida.

DATE REC'D BY LOCAL REG. 11-6-67
REGISTRAR'S SIGNATURE Lorraine K Brush
25. EMBALMER Billheuff
LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

DUTIES: APR 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5035
Local Reg. No. 224
Reg. Dist. No. 129

BIRTH NO.

RECEIVED NOV 20 1967 3-12 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (In this place): 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 531 Davidson St

3. NAME OF DECEASED (Type or Print)
a. (First): Bertha
b. (Middle):
c. (Last): Schultz

4. DATE OF DEATH: (Month) Nov (Day) 1 (Year) 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 5-3-1884

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Emerald Wis

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Bentley
BIRTHPLACE: Wis

14. MOTHER'S MAIDEN NAME: Theoda Sluyter
BIRTHPLACE: Mich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 349 09 2140

17. INFORMANT'S OWN SIGNATURE: B Robert Schultz
ADDRESS: CdA. Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 48 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Recent Cerebral Thrombosis — 1 week.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19 64, *to* 11-1, 19 67, *that I last saw the deceased alive on* 11-1, 19 67, *and that death occurred at* 3:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE: William T. Wood, M.D. 572 (Degree or title)
23b. ADDRESS: Coeur d'Alene Idaho
23c. DATE SIGNED: 11-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-3-67
24c. NAME OF CEMETERY OR CREMATORY: Forest
24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Oct. 7, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Gilbert Yates
LICENSE NO.: E-365

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5036
Local Reg. No. 223
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 281
a. COUNTY Kootenai
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) Coeur d'Alene Homes

3. NAME OF DECEASED (Type or Print)
a. (First) Anton
b. (Middle) 101
c. (Last) Howe

4. DATE OF DEATH (Month) (Day) (Year) November 2, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct 21, 1881
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumbering 17
10b. KIND OF BUSINESS OR INDUSTRY Lumber
11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Martin Howe — BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Karen (Unobtainable) — BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-01-0140
17. INFORMANT'S OWN SIGNATURE Mrs. Rudolph F. Hilgren — ADDRESS Ida. Coeur d'Alene

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

* 177X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 48 hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Metastatic Carcinoma Pelvis — 4 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, *19*50, *to* 11-2, *19*67, *that I last saw the deceased alive on* 11-2, *19*67, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) William T. Wood, M.D. 572
23b. ADDRESS Coeur d'Alene, Idaho
23c. DATE SIGNED 11-3-'67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-4-1967
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d'Alene (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 6, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Riplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Probable Source of Carcinoma was prostate although Biopsy in June was negative.

Certificate of Death

STATE OF IDAHO

State File No. 5037
Local Reg. No. 231
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 28
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 28 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 1124 N. 7th Street

3. NAME OF DECEASED (Type or Print): a. (First) Leo b. (Middle) W. c. (Last) Gushwa

4. DATE OF DEATH: (Month) Nov. (Day) 5, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Feb. 1, 1889

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Garage Owner 22

10b. KIND OF BUSINESS OR INDUSTRY: Own Garage

11. BIRTHPLACE (State or foreign country): Yuma, Colorado

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Gushwa — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Ella M. Hagerman — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-36-5188

17. INFORMANT'S OWN SIGNATURE: Frank L. Gushwa — ADDRESS: Ida. Lewiston

4221

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic cardiovascular disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Cholecystitis and choledocholithiasis

19a. DATE OF OPERATION: 11-2-67

19b. MAJOR FINDINGS OF OPERATION: Cholecystectomy & common duct exploration for cholecystitis and choledocholithiasis

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-31-67, *1967*, *to* 11-5, *1967*, *that I last saw the deceased alive on* 11-4, *19 67*, *and that death occurred at* 5:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. V. Culbertson, M.D. 087

23b. ADDRESS: Hayden Lake, Idaho

23c. DATE SIGNED: 11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-7-1967

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: 11-27-67

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: [illegible]

LICENSE NO.: E-397

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5038
Local Reg. No. 225
Reg. Dist. No. 120

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 1 — 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): 65 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 28 1 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 1914 7th St

3. NAME OF DECEASED (Type or Print): a. (First) Edith — b. (Middle) — c. (Last) Yarbrough

4. DATE OF DEATH: (Month) Nov (Day) 5 (Year) 1967

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Oct 2, 1880

9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 1 HR.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Unkown U.S.A.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unkown — BIRTHPLACE: Unkown

14. MOTHER'S MAIDEN NAME: Unkown — BIRTHPLACE: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 533 01 5872

17. INFORMANT'S OWN SIGNATURE: A I.D. P.A. — ADDRESS: CdA. Office

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Senility

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov, 1967, *to* Nov, 1967, *that I last saw the deceased alive on* Nov 5, 1967, *and that death occurred at* 6:15 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm Simmerdal MD 192

23b. ADDRESS: 302 W 5th

23c. DATE SIGNED: 7 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov 9, 1967

24c. NAME OF CEMETERY OR CREMATORY: Restlawn

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Nov. 9, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Gilbert Yates — LICENSE NO.: E-365

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 20 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5039
Local Reg. No. 2288
Reg. Dist. No. 120

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN: Coeur d' Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 330 Mills Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Margaret
b. (Middle): G.
c. (Last): Corley

4. DATE OF DEATH: Nov. 7, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 26, 1902

9. AGE (In years last birthday): 65
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Weatherford Center, Okla.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred Sanders
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME:
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-16-5394B

17. INFORMANT'S OWN SIGNATURE: Ben B Corley
ADDRESS: Cda. Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Pulmonary Emboli

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour):
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 10-3-67, 19___, *to* present, 19___, *that I last saw the deceased alive on* 11-7-67, 19___, *and that death occurred at* 5:50 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. A. Dougherty M.D.
23b. ADDRESS: 816 Sherman Ave., Coeur d'Alene Idaho
23c. DATE SIGNED: 11-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-10-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Nov. 17, 1967
REGISTRAR'S SIGNATURE: Lorraine L. Brush
25. EMBALMER:
LICENSE NO.: E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency / United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 22 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Fox

Certificate of Death

STATE OF IDAHO

State File No. 5040
Local Reg. No. 229
Reg. Dist. No. 120

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 1306 N. 6th St.

3. NAME OF DECEASED (Type or Print)
a. (First) Louise
b. (Middle) Almira 281
c. (Last) Jemison

4. DATE OF DEATH (Month) Nov. (Day) 7, (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 13, 1887
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook 01
10b. KIND OF BUSINESS OR INDUSTRY Burns-Yaak
11. BIRTHPLACE (State or foreign country) Echo, Oregon
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas H. McConnell — BIRTHPLACE N.Y.
14. MOTHER'S MAIDEN NAME Laura Anderson — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-03-2531A
17. INFORMANT'S OWN SIGNATURE Helen L. Becker — ADDRESS 1306 N. 6th Coeur d'Alene Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

464X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Thrombophlebitis, Rsaphenous vein — 3 wks
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 1, 1966, *to* Nov 7, 1967, *that I last saw the deceased alive on* Nov 7, 1967, *and that death occurred at* 7:05 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 174 (Degree or title) M.D.
23b. ADDRESS Coeur d'Alene Ida
23c. DATE SIGNED 11/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-8-1967
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d' Alene, (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 17, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Huff
LICENSE NO. E-439

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 22 1967

Certificate of Death

STATE OF IDAHO

State File No. 5041
Local Reg. No. 247
Reg. Dist. No. 12

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 081 (050)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 080
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Cyrus	H. 101	Hart	November 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	11-13-1882	85		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rural-Mail Carrier	U.S. Government	Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry T. Hart 08	Iowa	Mary Ricketts	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-56-9057	Hubert L. Hart	Post Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma, transverse colon — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
7-31-63	Complete obstruction transverse colon; liver metastasis	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-23-63, 1963, *to* 11-30, 1967, *that I last saw the deceased alive on* 11-29, 1967, *and that death occurred at* 6:45 am, *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. V. Callahan, M.D.	Hayden Lake, Idaho	12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	25. EMBALMER	LICENSE NO.
Burial	12-4-1967	Evergreen Cemetery	Post Falls, Idaho	Bill Neff	E-439

DATE REC'D BY LOCAL REG.: Dec. 18, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

FIRM NAME: English Chapel=Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 12 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5042
Local Reg. No. 230
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 1-19
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coe ur D' Alene
c. LENGTH OF STAY (in this place) 19 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spirit Lake
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Robert
b. (Middle) J.
c. (Last) Davis

4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 9-5-1890
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber man 17
10b. KIND OF BUSINESS OR INDUSTRY Retired
11. BIRTHPLACE (State or foreign country) Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Davis
BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Mary Ann Leeper
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) W.W. I 3
16. SOCIAL SECURITY NO. 475-07-6432A
17. INFORMANT'S OWN SIGNATURE Mrs. Angeline Davis
ADDRESS Spirit Lk, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CVA - — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-22, 1964, *to* 11-13, 1967, *that I last saw the deceased alive on* 11-13, 1967, *and that death occurred at* 11:15 *m., from the causes and on the date stated above.*

23a. SIGNATURE Alan M. Lanham 622 (Degree or title) MD
23b. ADDRESS Hayden Lake Idaho
23c. DATE SIGNED 11-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-16-1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
24d. LOCATION (City, town, or county) (State) Spirit Lake, Idaho

DATE REC'D BY LOCAL REG. 11-27-67
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred H. Noland
LICENSE NO. E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 1967

JAN 12 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 2 1990

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5043
Local Reg. No. 232
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
c. DEATH OF STAY (in this place) 0.00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ½ ml. W. Pst. Fls on hy 10

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spokane
d. STREET ADDRESS (If rural, give location) 213 N. Sullivan Road

3. NAME OF DECEASED (Type or Print)
a. (First) Ray
b. (Middle) 000 Burris
c. (Last) Weaver

4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 7-23-1935
9. AGE (In years last birthday) 32 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dry Wall Hanger 21
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Texas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Burris Weaver — BIRTHPLACE Texas
14. MOTHER'S MAIDEN NAME Winnie Deering — BIRTHPLACE Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 533-30-8930
17. INFORMANT'S OWN SIGNATURE Mrs. Karen Weaver, — ADDRESS Spokane, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) accidental trauma due to auto — INTERVAL BETWEEN ONSET AND DEATH immediate

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) accident
DUE TO (c) Crushed chest

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

8234

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT ~~SUICIDE~~ ~~HOMICIDE~~ (Specify) accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) U.S. Hwy #1006
21c. (CITY, TOWN, OR TOWNSHIP) 13 Post Falls — (COUNTY) 280 Kootenai — (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 0
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Car ran off road. Hit bank.

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE William T. Wood, M.D., 572 (Degree or title)
23b. ADDRESS Coeur d'alene Idaho
23c. DATE SIGNED 11-15-'67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11-14-1967
24c. NAME OF CEMETERY OR CREMATORY Thornhill Funeral Hom
24d. LOCATION (City, town, or county) Spokane, Washington (State)

DATE REC'D BY LOCAL REG. 11-27-67
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Fred H. Noland — LICENSE NO. E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUN 5 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 19 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5044
Local Reg. No. 235
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 316 LaCrosse 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 316 LaCrosse

3. NAME OF DECEASED (Type or Print)
a. (First): Irene
b. (Middle): E.
c. (Last): Mason

4. DATE OF DEATH (Month) (Day) (Year): Nov. 15 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 14, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Issac E. Hill — BIRTHPLACE: Finland
14. MOTHER'S MAIDEN NAME: Olga M. Markkanen — BIRTHPLACE: Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 521-52-4919
17. INFORMANT'S OWN SIGNATURE: C J Mason, 316 LaCrosse, Coeur d'Alene, Ida — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-12, 1967, *to* 11-15, 1967, *that I last saw the deceased alive on* 11-12, 1967, *and that death occurred at* 4:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ernest Barclay MD, 025
23b. ADDRESS: Coeur d'Alene, Ida
23c. DATE SIGNED: 11-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-18-1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Nov. 29, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: N. F. Riplinger
LICENSE NO.: E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5045
Local Reg. No. 233
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 280 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2 Miles east Hiway #10 008

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Robert
b. (Middle): Raiden
c. (Last): Williamson

4. DATE OF DEATH: (Month) Nov (Day) 16 (Year) 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 8 1944

9. AGE (In years last birthday): 23
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor 08

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Forest Serv

11. BIRTHPLACE (State or foreign country): Coeur d'Alene Ida

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lester Williamson
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Bernice Antoine
BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518 52 4944

17. INFORMANT'S OWN SIGNATURE: Mrs. Linda Williamson
ADDRESS: Post Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Accidental Traumatism due — INTERVAL BETWEEN ONSET AND DEATH: Ida

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): to auto accident — Immediate
DUE TO (c): Skull Fracture — "

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT (Specify) / ~~SUICIDE~~ / HOMICIDE: accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): U.S. #10. 06

21c. (CITY, TOWN, OR TOWNSHIP) 13 Post Falls (COUNTY) 280 Kootenai (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Car ran offroad and rolled over

22. *I hereby certify that I attended the deceased from* Did not, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 10:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE: William T. Wood M.D. (Degree or title) Coroner 583

23b. ADDRESS: Coeur d'alene Idaho

23c. DATE SIGNED: 11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-20-67

24c. NAME OF CEMETERY OR CREMATORY: Restlawn

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: 11-27-67

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland
LICENSE NO.: E-

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Yates Funeral Home

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5046
Local Reg. No. 228
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 1 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 801 Lakeside Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Fred
b. (Middle) E. 101
c. (Last) Bailey

4. DATE OF DEATH (Month) Nov. (Day) 19, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 8-25-1882
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Woodsman 17
10b. KIND OF BUSINESS OR INDUSTRY Sawmill
11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Charlie Bailey — BIRTHPLACE Minn.
14. MOTHER'S MAIDEN NAME ? Poler — BIRTHPLACE Minn.
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-03-2871
17. INFORMANT'S OWN SIGNATURE X [signature] — ADDRESS Spokane, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardio Vascular Disease — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-16, 1965, *to* Nov. 19, 1967, *that I last saw the deceased alive on* Nov 19, 1967, *and that death occurred at* 10:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 530 (Degree or title) MD.
23b. ADDRESS 318 Elder Bldg. Coeur d'Alene, Idaho
23c. DATE SIGNED 11-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-22-1967
24c. NAME OF CEMETERY OR CREMATORY Pinegrove Cemetery
24d. LOCATION (City, town, or county) Rathdrum, (State) Idaho

DATE REC'D BY LOCAL REG. 11-27-67
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER [signature]
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel-Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 1 3 1992

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Barney Cherly

Certificate of Death

STATE OF IDAHO

State File No. 5047
Local Reg. No. 2947
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 1 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 403 Dollar St.

3. NAME OF DECEASED (Type or Print)
a. (First) Myrtle
b. (Middle) M. 101
c. (Last) Bowen

4. DATE OF DEATH (Month) (Day) (Year) November 19, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH June 6, 1900

9. AGE (In years last birthday) 67
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Beautician 21

10b. KIND OF BUSINESS OR INDUSTRY Own Business

11. BIRTHPLACE (State or foreign country) Dayton, Wash.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Farmer Bowen
BIRTHPLACE Wisc.

14. MOTHER'S MAIDEN NAME Iva Sparks
BIRTHPLACE Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 519-36-2924

17. INFORMANT'S OWN SIGNATURE Irene A. Bowen, ADDRESS Coeur d'alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ASHD.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-25-61, 19____, *to* present, 19____, *that I last saw the deceased alive on* 11-19-67, 19____, *and that death occurred at* 5:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE 128 (Degree or title)

23b. ADDRESS D. A. BAUMAN M.D. 816 SHERMAN AVE. COEUR D'ALENE, IDAHO

23c. DATE SIGNED NOV 22 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-22-1967

24c. NAME OF CEMETERY OR CREMATORY Restlawn Memoriak Pk.

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG. 11-27-67

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER N. F. Ripling, Jr.

LICENSE NO. E-397

FIRM NAME English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5048
Local Reg. No. 252
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 22 1967

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN Coeur d'Alene
c. LENGTH OF STAY (in this place) 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 280
c. CITY OR TOWN Worley
d. STREET ADDRESS (If rural, give location) **

3. NAME OF DECEASED (Type or Print): a. (First) Leonard b. (Middle) (NMI) c. (Last) Sheehan

4. DATE OF DEATH (Month) (Day) (Year): Nov. 21, 1967

5. SEX: M.

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: 6-22-1887

9. AGE (In years last birthday): 80 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): (ret) general farm laborer

10b. KIND OF BUSINESS OR INDUSTRY: 69

11. BIRTHPLACE (State or foreign country): San Francisco, Calif.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Not available — BIRTHPLACE: Ireland

14. MOTHER'S MAIDEN NAME: not available — BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unknown (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 725 10 2456

17. INFORMANT'S OWN SIGNATURE: Iris Ambro — ADDRESS: Tensed, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* advanced pulmonary tuberculosis — Years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1957, *to* 11-21, 1967, *that I last saw the deceased alive on* 11-21, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: William T. Wood M.D. 573 (Degree or title)

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 11-25-67

24c. NAME OF CEMETERY OR CREMATORY: Worley cemetery

24d. LOCATION (City, town, or county) (State): Worley, Idaho

DATE REC'D BY LOCAL REG.: Dec. 14, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland — LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-10087 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5049
Local Reg. No. 236
Reg. Dist. No. 120

BIRTH NO.

DEC 14 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 25 dys.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 813 Montana Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Patricia b. (Middle) L. c. (Last) Anderson

4. DATE OF DEATH (Month) Nov. (Day) 21, (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH 10-26-1967

9. AGE (In years last birthday) — IF UNDER 1 YEAR Months — Days 25 — IF UNDER 24 HRS. Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Coeur d' Alene, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frances L. Anderson, — BIRTHPLACE Utah

14. MOTHER'S MAIDEN NAME Judy Raybell — BIRTHPLACE Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE Frances L. Anderson, — ADDRESS Cd'A, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7630 Viral pneumonia, Acute, severe. — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) —
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/26/67, 19—, *to* 11/21/67, 19—, *that I last saw the deceased alive on* Nov. 10, 1967, *and that death occurred at* 3:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Lynn C. Fredrickson (Degree or title) MD

23b. ADDRESS Coeur d' Alene, Idaho.

23c. DATE SIGNED 11/29/67.

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-24-1967

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Dec. 11, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5050
Local Reg. No. 234
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 1 1967 Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene Bureau
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location): Rt. #2

3. NAME OF DECEASED (Type or Print): a. (First) Adelaide b. (Middle) L. 101 c. (Last) Brickert

4. DATE OF DEATH: (Month) Nov. (Day) 24, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aug. 22, 1895

9. AGE (In years last birthday): 72 | IF UNDER 1 YEAR Months: Days | IF UNDER 24 HRS. Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Hayes — BIRTHPLACE: Ill.

14. MOTHER'S MAIDEN NAME: Charlotte Anthony — BIRTHPLACE: Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-14-5773

17. INFORMANT'S OWN SIGNATURE & ADDRESS: Mrs. Harley G. Brickert Ida Post Falls,

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastric hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Stomach — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1517

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 10, 19 67, *to* Nov 24, 19 67, *that I last saw the deceased alive on* Nov 23, 19 67, *and that death occurred at* 3 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: C E Thompson 530 — (Degree or title): M.D. — **23b. ADDRESS**: 318 Elder Bldg. Coeur d Alene Idaho — **23c. DATE SIGNED**: 11-24, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 11-27-1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Forest Cemetery — **24d. LOCATION** (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Nov 29, 1967 — **REGISTRAR'S SIGNATURE**: Lorraine K. Brush

25. EMBALMER: Bill Leuff — **LICENSE NO.**: E-439

FIRM NAME: English Chapel=Coeur d' Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5051
Local Reg. No. 249
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 14 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rathdrum
c. LENGTH OF STAY IN (Hospital or Institution) (If dead on arrival, or found dead, leave blank): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. #1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 280
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rathdrum
d. STREET ADDRESS (If rural, give location): Rt. #1

3. NAME OF DECEASED (Type or Print): a. (First) Henry; b. (Middle) Oliver; c. (Last) Martin

4. DATE OF DEATH (Month) (Day) (Year): November 26, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Oct. 6, 1884

9. AGE (In years last birthday): 83 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Shift Foreman 26

10b. KIND OF BUSINESS OR INDUSTRY: Paper Mill

11. BIRTHPLACE (State or foreign country): Port Edwards, Wisc.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry O. Martin
BIRTHPLACE: Canada

14. MOTHER'S MAIDEN NAME: Mary F. Meinier
BIRTHPLACE: Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 536-05-4843

17. INFORMANT'S OWN SIGNATURE: Mrs. Stan Martin, ADDRESS: Rathdrum Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Wood M.D. Coroner 583

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 11-28-'67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-29-1967

24c. NAME OF CEMETERY OR CREMATORY: St. Thomas Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Dec. 1, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Breesh

25. EMBALMER: Bill Duff

LICENSE NO.: E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5052
Local Reg. No. 248
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 DEC 14 1967 3-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give place) Coeur d' Alene
c. LENGTH OF STAY 5 dyas
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE 05 California
b. COUNTY 333 Los Angeles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Los Angeles
d. STREET ADDRESS (If rural, give location) 8925 Beverlywood St.

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) 101 c. (Last) Lester

4. DATE OF DEATH (Month) (Day) (Year) November 27, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 10-21-1892
9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodian 06
10b. KIND OF BUSINESS OR INDUSTRY School System
11. BIRTHPLACE (State or foreign country) Mass.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Not Available — BIRTHPLACE Not available
14. MOTHER'S MAIDEN NAME Not available — BIRTHPLACE Not available

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 573-56-0305
17. INFORMANT'S OWN SIGNATURE ADDRESS X Bessie M. Strand, 1104 Indiana

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular accident (Stroke) — INTERVAL BETWEEN ONSET AND DEATH 1 week.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Uremia — over 1 week

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from [redacted], 1967, to 11-27, 1967, that I last saw the deceased alive on 11-27, 1967, and that death occurred at ____ m., from the causes and on the date stated above.

23a. SIGNATURE William T. Wood (Degree or title) M.D.
23b. ADDRESS Coeur d'alene Idaho
23c. DATE SIGNED 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11-29-1967
24c. NAME OF CEMETERY OR CREMATORY Forest Lawn Memorial Pk.
24d. LOCATION (City, town, or county) Los Angeles, (State) Calif.

DATE REC'D BY LOCAL REG. Dec. 1, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Duff
LICENSE NO. E-439
FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 5 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Tyon

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5053
Local Reg. No. 243
Reg. Dist. No. 120

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 DEC 14 1967 3-04
b. CITY OR TOWN: Coeur d'Alene
c. LENGTH OF STAY (In this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 38 Oregon
b. COUNTY: 555 Linn
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Albany
d. STREET ADDRESS (If rural, give location): 815 Burkhart

3. NAME OF DECEASED (Type or Print): a. (First) Harriet b. (Middle) L c. (Last) Reasor

4. DATE OF DEATH: (Month) 11 (Day) 27 (Year) 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: June 6 1882

9. AGE (In years last birthday): 85 IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Tenn

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Asa F. Shepherd BIRTHPLACE: Ga.

14. MOTHER'S MAIDEN NAME: Nancy Covington BIRTHPLACE: Tenn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Lawrence Reasor ADDRESS: CdA. Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Perforated Duodenal Ulcer — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Arteriosclerotic Heart disease — year

19a. DATE OF OPERATION: 11-24-67

19b. MAJOR FINDINGS OF OPERATION: Perforated Duodenal Ulcer

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-24, 1967, *to* 11-27, 1967, *that I last saw the deceased alive on* 11-27, 1967 *and that death occurred at* 2:10 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 313 (Degree or title): M.D.

23b. ADDRESS: 411 Coeur d'Alene Ave. CDA

23c. DATE SIGNED: 11-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-1-67

24c. NAME OF CEMETERY OR CREMATORY: Skyline Mem. Garden

24d. LOCATION (City, town, or county) (State): Portland Oregon

DATE REC'D BY LOCAL REG.: Dec. 11, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home CdA.

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 22 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Dr Wood

Certificate of Death

STATE OF IDAHO

State File No. 5054
Local Reg. No. 242
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 14 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 3-13
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 13 Idaho
b. COUNTY: 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 959 N 6th St

3. NAME OF DECEASED (Type or Print)
a. (First): Herman
b. (Middle): R.
c. (Last): Nixon

4. DATE OF DEATH (Month) (Day) (Year): Nov 29 67

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 9-1-1907
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Tree Sawyer 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Oklahoma
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard Nixon — BIRTHPLACE: Ill.
14. MOTHER'S MAIDEN NAME: Louise Tricene — BIRTHPLACE: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 514 01 5399
17. INFORMANT'S OWN SIGNATURE: Mrs. Rosemond Nixon — ADDRESS: CdA. Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9217

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): accidental aspiration Gastric Contents — INTERVAL BETWEEN ONSET AND DEATH: 2 hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Metastatic Carcinoma probable Melanoma — Several months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* — *, 19*64*, to* 11-29*, 19*67*, that I last saw the deceased alive on* 11-29*, 19*67*, and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): William T. Wood M.D. 572
23b. ADDRESS: Coeur d'alene, Idaho
23c. DATE SIGNED: 12-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-2-67
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Dec 11, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Fred Noland — LICENSE NO.: E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

DUTIES:

JAN 17 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5055
Local Reg. No. 247
Reg. Dist. No. 120

RECEIVED DEC 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 3-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place) 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 702 CdA. Ave

3. NAME OF DECEASED (Type or Print) a. (First) Joseph b. (Middle) c. (Last) Wilkum

4. DATE OF DEATH (Month) 11 (Day) 30 (Year) 67

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 8-31-1920

9. AGE (In years last birthday) 47 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 05

10b. KIND OF BUSINESS OR INDUSTRY Natl Guard

11. BIRTHPLACE (State or foreign country) Bannville Mont

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ole Wilkum BIRTHPLACE Unkown

14. MOTHER'S MAIDEN NAME Mable Rongstad BIRTHPLACE Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. II

16. SOCIAL SECURITY NO. 516 16 9822

17. INFORMANT'S OWN SIGNATURE Mrs. Helen Wilkum ADDRESS CdA. Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Possible cardiac arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Posterior myocardial infarction — 7-10 days
DUE TO (c) Recurrent Thrombus Rt coronary art — same.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Previous myocardial infarctions — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 23, 1967, *to* Nov 30, 19 67, *that I last saw the deceased alive on* Nov 30, 19 67, *and that death occurred at* 7:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) W. Wray Wilson MD 568

23b. ADDRESS Coeur d'Alene Idaho

23c. DATE SIGNED 12/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-4-67

24c. NAME OF CEMETERY OR CREMATORY Restlawn

24d. LOCATION (City, town, or county) (State) Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG. Dec. 11, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred Noland LICENSE NO. E- 493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1967

JAN 17 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5056
Local Reg. No. 148
Reg. Dist. No. 200

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow 000
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Paradise Valley Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 1006 Sherman

3. NAME OF DECEASED (Type or Print) a. (First) Delmar b. (Middle) 329 B. c. (Last) Clement

4. DATE OF DEATH (Month) (Day) (Year) Nov 1 67

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH 9-1-1905

9. AGE (In years last birthday) 62
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor 11

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Dassel Minn

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Claude Clement BIRTHPLACE Minn

14. MOTHER'S MAIDEN NAME Minnie Mattson BIRTHPLACE Minn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 513 03 9796

17. INFORMANT'S OWN SIGNATURE Idaho D.P.A. Office ADDRESS CdA. Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of unknown primary — INTERVAL BETWEEN ONSET AND DEATH 2-3 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

1992

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Nov. 1, 1967, *that I last saw the deceased alive on* Oct. 30, 1967, *and that death occurred at* 3:17 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward L Doas 788 (Degree or title) MD

23b. ADDRESS Professional Bldg. Moscow

23c. DATE SIGNED 11-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov 6 1967

24c. NAME OF CEMETERY OR CREMATORY Restlawn

24d. LOCATION (City, town, or county) (State) Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE Cheryl Williams

25. EMBALMER Gilbert Yates LICENSE NO. E-365

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5057
Local Reg. No. 142
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 13 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 — 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow — LENGTH OF STAY (In this place): 18 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 773 Brent Drive

3. NAME OF DECEASED (Type or Print): a. (First) Lafayette — b. (Middle) Junior 329 — c. (Last) Castimore

4. DATE OF DEATH: (Month) (Day) (Year): November 1, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: September 28, 1902

9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roofing 21

10b. KIND OF BUSINESS OR INDUSTRY: Roofing

11. BIRTHPLACE (State or foreign country): Dover New Jersey

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Samuel Castimore — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Sarah E. Jaquins — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 321-108-859A

17. INFORMANT'S OWN SIGNATURE: X Mrs H T Goodnough — ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Carcinoma of Lung — 1-2 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

163X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Nov. 1, 1967, *that I last saw the deceased alive on* Nov. 1, 1967, *and that death occurred at* 4:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edward L Bass MD 788

23b. ADDRESS: Prof. Bldg. Moscow

23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-4-67

24c. NAME OF CEMETERY OR CREMATORY: Albion Cemetery

24d. LOCATION (City, town, or county) (State): Albion Washington

DATE REC'D BY LOCAL REG.: 11-10-67

REGISTRAR'S SIGNATURE: Cheryl Ann Williams

25. EMBALMER: Donald Ward — LICENSE NO.: E-380

FIRM NAME: Short's Funeral Chapel Moscow, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 1 4 1967

Certificate of Death

STATE OF IDAHO

State File No. 5058
Local Reg. No. 149
Reg. Dist. No. 200

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 29 — 3-12
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (In this place) 12 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 29
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print) a. (First) Llewellyn b. (Middle) 112 Thomas c. (Last) Roberts

4. DATE OF DEATH (Month) (Day) (Year) November 5, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH October 12, 1879

9. AGE (In years last birthday) 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter 21

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Red Elephant, Colorado

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hugh H. Roberts — BIRTHPLACE Wales

14. MOTHER'S MAIDEN NAME Elizabeth Thomas — BIRTHPLACE Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 518-05-2743

17. INFORMANT'S OWN SIGNATURE X Llewellyn R Roberts — ADDRESS Fresno, California

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema - Congestive failure — INTERVAL BETWEEN ONSET AND DEATH 3 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 29, 1967, *to* Nov. 5, 1967, *that I last saw the deceased alive on* Nov. 5, 1967, *and that death occurred at* 6:10P m., *from the causes and on the date stated above.*

23a. SIGNATURE Edward L Deas 788 (Degree or title)

23b. ADDRESS Professional Bldg. Moscow

23c. DATE SIGNED 11-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-7-67

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens

24d. LOCATION (City, town, or county) (State) Moscow Latah Idaho

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE Cheryl Williams

25. EMBALMER Fred J Nelson

LICENSE NO. E-504

FIRM NAME: Shasta Funeral Chapel Moscow, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

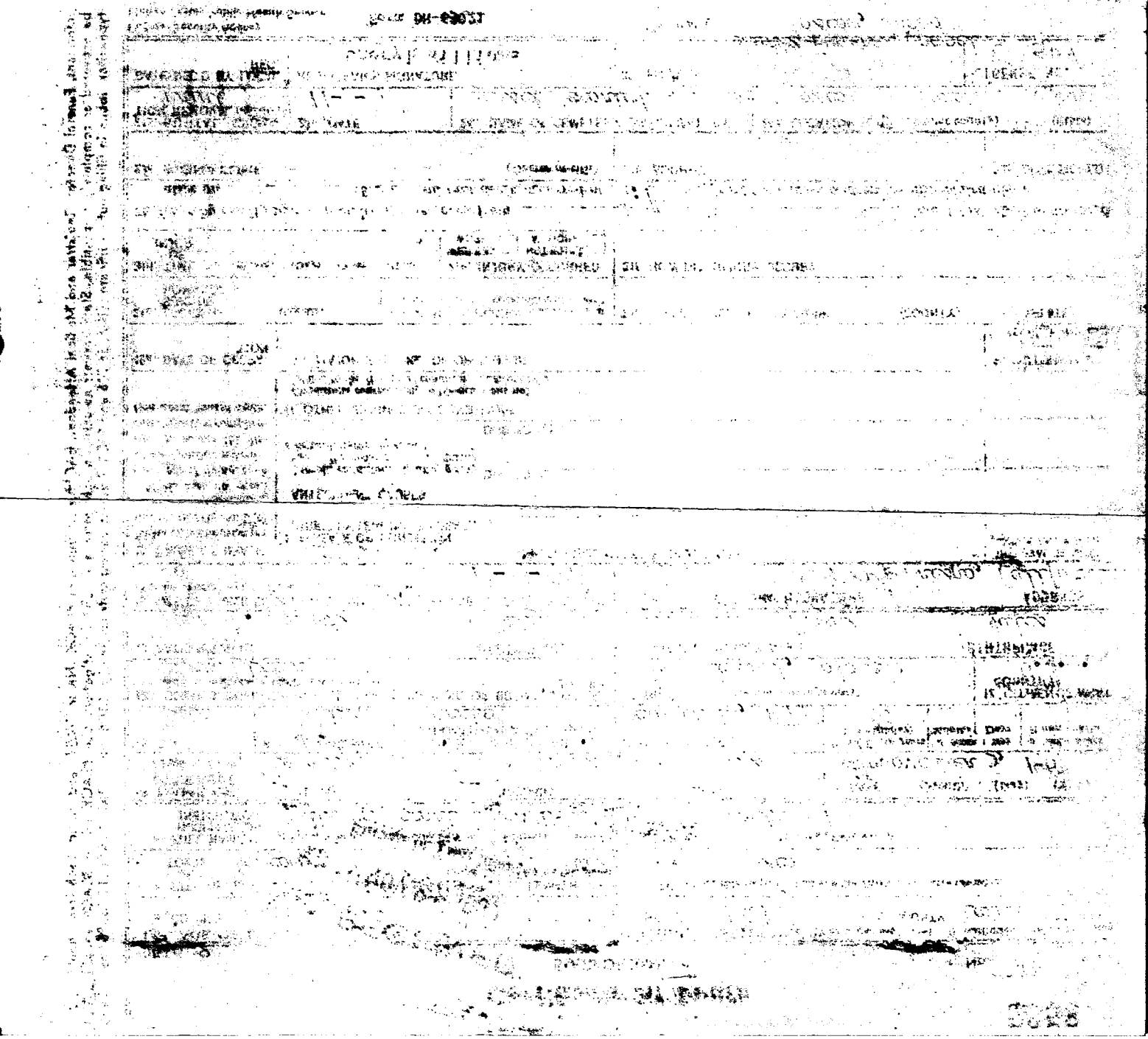

67-5058

DISINTERMENT PERMIT

DEPARTMENT OF HEALTH AND WELFARE
Bureau of Vital Statistics
Boise, Idaho

APPLICATION HAVING BEEN MADE for the disinterment of the body of LLEWELLYN T. ROBERTS now lying buried in SUNSET MEMORIAL GARDENS Cemetery, in the City or Town of MOSCOW County of LATAH State of Idaho, who died on the 5th day of NOVEMBER 19 67, Aged 88 years ____ months ____ days, the cause of death being Pulmonary edema-congestive failure and not directly or indirectly by diphtheria; scarlet fever; smallpox; leprosy, asiatic cholera; typhus fever or yellow fever as shown by the certificate of death of said deceased, given by Edward L. Boas, M.D. attending physician.

THIS IS TO CERTIFY that permission is hereby given for such disinterment and removal by PRIVATE (private or public conveyance) to SUNSET MEMORIAL PARK Cemetery in the City or Town of TWIN FALLS County of TWIN FALLS State of IDAHO to take effect upon the approval by the local health officer of the City, Town, or County of LATAH it being understood and provided that nothing herein shall be deemed as contravening or in anyway modifying or releasing the regulations of the Department of Health and Welfare governing the transportation of bodies or the requirements for a transportation permit, and all transportation companies and common carriers will be governed accordingly; and provided further, that where the disinterment is for the purpose of reinterment in another part of the same cemetery, or in a contiguous cemetery, the removal shall not be made by any public conveyance. The disinterment and removal must be done under the personal supervision of a licensed embalmer in good standing.

Janet M. Wick by Joyce B. Folk
State Registrar, Bureau of Vital Statistics
Department of Health and Welfare

August 25, 1980
Date

Permit issued to:
Ronald J. Hamilton - M470
White Mortuary
Box 845
Twin Falls, Idaho 83301

The foregoing application for disinterment and removal is hereby approved by the Local Health Officer of the City, Town or County of Latah, State of Idaho.

X _____
Local Health Officer

X _____
Date

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5059
Local Reg. No. 144
Reg. Dist. No. 200

BIRTH NO.

NOV 14 1967

Bureau of Vital Statistics

3-07

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 7 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Michigan 23
b. COUNTY: 655 Unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Quincy
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print): a. (First) Florence; b. (Middle) M.; c. (Last) Campbell

4. DATE OF DEATH: (Month) Nov (Day) 5 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: July 25, 1880

9. AGE (In years last birthday): 87 (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Reading, Mich.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Luther H. Fitzsimmons — BIRTHPLACE: Mich.

14. MOTHER'S MAIDEN NAME: Ellen R. Cook — BIRTHPLACE: Mich.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 378-52-8411

17. INFORMANT'S OWN SIGNATURE: X Kenneth E. Campbell — ADDRESS: Quincy, Mich

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Small Bowel Obstruction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Renal Failure

5705

19a. DATE OF OPERATION: 11-3-67

19b. MAJOR FINDINGS OF OPERATION: Obstruction Ileum

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: David C. Valder — (Degree or title): MD

23b. ADDRESS: Moscow Idaho

23c. DATE SIGNED: 11-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Nov 6, 1967

24c. NAME OF CEMETERY OR CREMATORY: Maplewood Cemetery

24d. LOCATION (City, town, or county) (State): Reading, Mich.

DATE REC'D BY LOCAL REG.: 11-13-67

REGISTRAR'S SIGNATURE: Sheryll Ann Williams

25. EMBALMER: Ronald Ward

LICENSE NO.: E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 1 4 1967

Certificate of Death

STATE OF IDAHO

State File No. 5060
Local Reg. No. 145
Reg. Dist. No. 200

RECEIVED NOV 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 291 — 4-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow — LENGTH OF STAY (in this place) 6 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13 — b. COUNTY 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 117 West A St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Alice	Marie	McBride		Nov	5	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	married 3	Dec 12, 1911	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Potlatch, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lowell Thrasher — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 532-32-0001
17. INFORMANT'S OWN SIGNATURE: Wiley McBride — ADDRESS: Moscow, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1993 General Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ascites — 1 month

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
10-23-67	6000 ± 7 Fluid in Abdomen from Cancer	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-10, 1947, *to* 11-5, 1967, *that I last saw the deceased alive on* 11-5, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Earl W Dunn 149 MD	Moscow Idaho	11-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 7, 1967	Freeze Cemetery	Potlatch Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-13-67	Cheryl Ann Williams	Donald Ward	E-80

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 4 1967

FEB 1 2 1968

Certificate of Death

STATE OF IDAHO

State File No. 5061
Local Reg. No. 150
Reg. Dist. No. 200

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 291 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 15 Indiana
b. COUNTY: 555 Unknown
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Wayne
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Esther	Margaret	Geiser	Nov	6	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	widowed 2	March 3, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fort Wayne, Indiana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Selig	Indiana	Mary Boerger	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 317-10-0595
17. INFORMANT'S OWN SIGNATURE: x Donald W. Geiger ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Nov., 1967, *that I last saw the deceased alive on* 6 Nov., 1967, *and that death occurred at* 2 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. P. Marineau, M. D. 328	129 W.Third St.,Moscow,Ida.	11-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 7, 1967	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Cheryl Williams	Donald Ward	E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

NOV 27 1967

State File No. 5062
Local Reg. No. 146
Reg. Dist. No. 200

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 NOV 14 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY: Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 315 E. 5th St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 13 Idaho
b. COUNTY: 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 315 E. 5th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Tom
b. (Middle): Mitchell
c. (Last): Schultz

4. DATE OF DEATH (Month) (Day) (Year): Nov 6 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Feb 14, 1924
9. AGE (In years last birthday): 43 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): postal service 08
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Clayton, N.M.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Schultz — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Mary B. Dillehy — BIRTHPLACE: Tenn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 2 4
16. SOCIAL SECURITY NO.: 518-22-5857
17. INFORMANT'S OWN SIGNATURE: x Bridget L. Schultz — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suicide - Self inflicted gunshot wound of head — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

976X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP): 13 Moscow — (COUNTY): Latah 291 — (STATE): Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Nov. 6 1967 8:45 a.m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Self inflicted

22. *I hereby certify that I attended the deceased from* Aug 1 *19*__, *to* _____, *19*__, *that I last saw the deceased alive on* _____, *19*__, *and that death occurred at* 9:00 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: 583 (Degree or title) Dr. Brooks M.D. Co. Coroner
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: Nov. 18, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Nov 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county): Moscow — (State): Idaho

DATE REC'D BY LOCAL REG.: 11-13-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Fred J. Nelson — LICENSE NO.: E-504

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 4 1967

JUN 7 1968

State File No. 5063
Local Reg. No. 147
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 3-11
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 524 No. Blaine

3. NAME OF DECEASED (Type or Print)
a. (First): Carol
b. (Middle):
c. (Last): Guthrie

4. DATE OF DEATH (Month) Nov (Day) 7 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married 1
8. DATE OF BIRTH: Aug 29, 1951
9. AGE (In years last birthday): 16 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baraboo, Wisconsin
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Guthrie — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Dorothy Simpson — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X James W. Guthrie — ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

590X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 13 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Acute Glomerulonephritis — 13 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Rheumatoid arthritis — 15 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1962, *to* Nov 7, 1967, *that I last saw the deceased alive on* Nov 7, 1967, *and that death occurred at* 3:09 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. Adams, MD (Degree or title) 001
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 11/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Nov 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 11-13-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

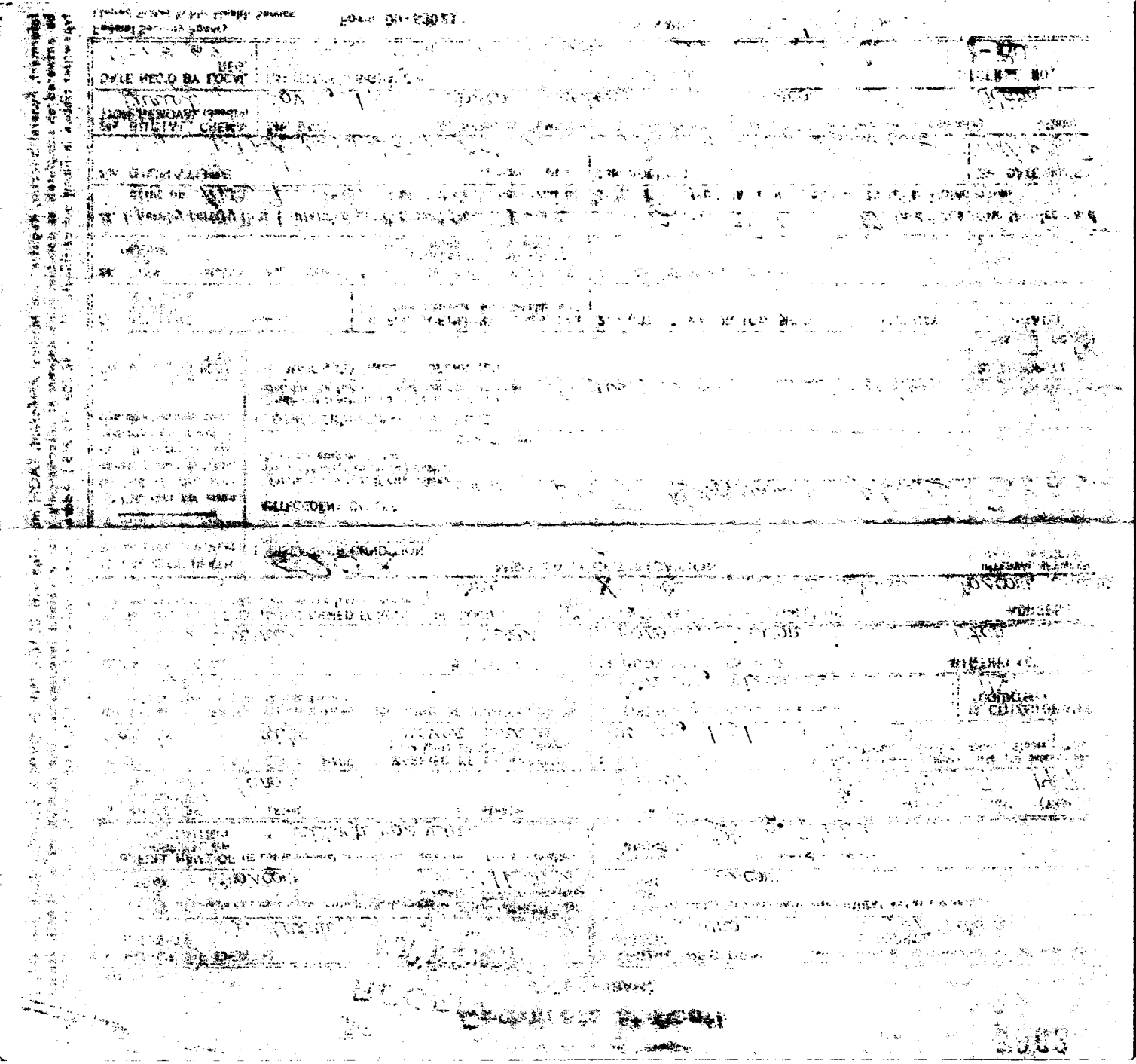

State File No. 5064
Local Reg. No. 151
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 291 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (In this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 290 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Potlatch
d. STREET ADDRESS (If rural, give location): 910 Spruce St.

3. NAME OF DECEASED (Type or Print)
a. (First): LEONARD
b. (Middle): ARNOLD
c. (Last): DOTY

4. DATE OF DEATH (Month) (Day) (Year): Nov. 9, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: May 4, 1922
9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sawyer 17
10b. KIND OF BUSINESS OR INDUSTRY: PFI Saw Mill
11. BIRTHPLACE (State or foreign country): Saco, Montana
12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Willis Doty — BIRTHPLACE: Penn.
14. MOTHER'S MAIDEN NAME: Rosella Timmerman — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW2 4
16. SOCIAL SECURITY NO.: 518-20-1195
17. INFORMANT'S OWN SIGNATURE: Mrs Leonard Doty — ADDRESS: Potlatch, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-10, 1948, *to* 11-9, 1967, *that I last saw the deceased alive on* 11-9, 1967, *and that death occurred at* 7:10 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gerald N Dunn 149
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 11-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-13-1967
24c. NAME OF CEMETERY OR CREMATORY: Freeze Cemetery
24d. LOCATION (City, town, or county) (State): Latah County, Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE: Cheryl Williams
25. EMBALMER: H E Kimball — LICENSE NO. E269

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Kimball Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 27 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5065
Local Reg. No. 152
Reg. Dist. No. 200

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (in this place) Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 443 Lewis

3. NAME OF DECEASED (Type or Print)
a. (First) Jesse
b. (Middle) Alfred
c. (Last) Borgen

4. DATE OF DEATH (Month) (Day) (Year) Nov. 14, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH June 8, 1891

9. AGE (In years last birthday) 76
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tax Consultant 21

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Genesee, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Anton Borgen
BIRTHPLACE Norway

14. MOTHER'S MAIDEN NAME Rena Thompson
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) W. W. I 3

16. SOCIAL SECURITY NO. 518225427 A

17. INFORMANT'S OWN SIGNATURE Mrs Jess Borgen
ADDRESS Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Cerebral Hemorrhage Sudden — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral Arteriosclerosis 10 years
DUE TO (c) Generalized Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

331X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-6-, 1967, *to* 11-14-, 1967, *that I last saw the deceased alive on* 11-14-, 1967, *and that death occurred at* 2:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Joseph G. Wilson 567 (Degree or title) M.D.

23b. ADDRESS Moscow, Idaho

23c. DATE SIGNED 11-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 17, 1967

24c. NAME OF CEMETERY OR CREMATORY Genesee Valley Cemetery

24d. LOCATION (City, town, or county) Genesee (State) Idaho

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE Cheryl Williams

25. EMBALMER Fred J. Nelson

LICENSE NO. E-504

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

FEB 12 1968

FEB 13 1968

JUL 8 1976

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5066
Local Reg. No. 153
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED

Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 241 DEC 5 1967 1-46
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (In this place) 46 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 602 South Admas 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 241
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location) 602 South Admas

3. NAME OF DECEASED (Type or Print) a. (First) Helen b. (Middle) Marie c. (Last) Packenham

4. DATE OF DEATH (Month) (Day) (Year) November 18, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH April 15, 1897

9. AGE (In years last birthday) 70
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Homemaker

11. BIRTHPLACE (State or foreign country) Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur Woods
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Annis Pulliam
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-24-9895

17. INFORMANT'S OWN SIGNATURE J. C. Packenham
ADDRESS Walnut Creek, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary arteriosclerosis — years

DUE TO (c) Chronic myocarditis — 3 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Bronchitis (asthma) — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-11-35, to 11-18-67, that I last saw the deceased alive on 11-14-1967, and that death occurred at 9:30A m., from the causes and on the date stated above.

23a. SIGNATURE Joseph E. Wilson 567 (Degree or title) M.D.

23b. ADDRESS Moscow, Idaho

23c. DATE SIGNED 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-21-67

24c. NAME OF CEMETERY OR CREMATORY Moscow, Cemetery

24d. LOCATION (City, town, or county) Moscow, Latah (State) Idaho

DATE REC'D BY LOCAL REG. 12-1-67

REGISTRAR'S SIGNATURE Cheryl Ann Williams

25. EMBALMER Donald Ward

LICENSE NO. E-80

FIRM NAME: Short's Funeral Chapel Moscow, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

AUG 21 1981

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 39-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5067
Local Reg. No. 154
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 25 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 412 North Howard

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Sister	Patricia	Kelley	Nov. 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Never Married	Sept. 8, 1873	94		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Nun 18	Ursuline	Ireland	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Patrick Kelley	Ireland	Mary Downs	Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	X Mother Damien Mullen	Moscow, Ida.

18. CAUSE OF DEATH 4208

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis, general — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1954, *to* Nov 22, 1967, *that I last saw the deceased alive on* Nov 22, 1967, *and that death occurred at* 6:23 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W R Adams 001, M.D.	Moscow, Idaho	Nov 26, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 24, 1967	Moscow Catholic Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-1-67	Cheryl Ann Williams	Donald Ward	E-80

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Short's Funeral Chapel

Certificate of Death

STATE OF IDAHO

RECEIVED

DEC 6 1937

Bureau of Vital Statistics

Boise

Idaho

Boise

Idaho County

Idaho

Idaho Hospital

Sister

Patricia

Female

Nov. 22, 1937

White

Never Married

Sept. 1, 1[illegible]

Unaline

Prescott

Prescott

Idaho

None

Idaho, Idaho

DISEASE OR CONDITION

ANTECEDENT CAUSES

Nov. 24, 1937

Idaho

Idaho County

Idaho

Idaho County Public Health Service

Form DH-53621

Mont's Funeral Chapel

State File No. 5068
Local Reg. No. 155
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED DEC 5 1967 3-06

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Memorial Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genessee
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Anna
b. (Middle): Margarette
c. (Last): Harris

4. DATE OF DEATH (Month) (Day) (Year): November 23, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: August 17, 1879
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Homemaker
11. BIRTHPLACE (State or foreign country): Redwing Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard Hazen Downing — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Catherine S. Churton — BIRTHPLACE: Minnestoa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-60-7522 D
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Genessee, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 151X Carcinoma Stomach

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* _____, 1965, *that I last saw the deceased alive on* 11-23, 1967, *and that death occurred at* 12:40 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David C Valdo MD 541
23b. ADDRESS: Moscow Ida
23c. DATE SIGNED: 11-27

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-27-67
24c. NAME OF CEMETERY OR CREMATORY: Genessee City Cemetery
24d. LOCATION (City, town, or county) (State): Genessee Latah Idaho

DATE REC'D BY LOCAL REG.: 12-1-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Fred J. Nelson
LICENSE NO.: E-504

FIRM NAME: Short's Funeral Chapel, Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

JAN 29 1968

State File No. 5069
Local Reg. No. 158
Reg. Dist. No. 200

Certificate of Death

RECEIVED DEC 1 1 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Latah 290 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Genesee
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home Genesee 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 290 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Genesee
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Philip
b. (Middle) David
c. (Last) Spechko

4. DATE OF DEATH (Month) (Day) (Year) November 25, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 20, 1918
9. AGE (In years last birthday) 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Physician 12
10b. KIND OF BUSINESS OR INDUSTRY Physician
11. BIRTHPLACE (State or foreign country) Max North Dakota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Aaron Spechko — BIRTHPLACE Ukrainia
14. MOTHER'S MAIDEN NAME Alexandria Kovalenko — BIRTHPLACE Ukrainia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW II
16. SOCIAL SECURITY NO. 518-03-1852
17. INFORMANT'S OWN SIGNATURE Mrs. Philip D. Spechko — ADDRESS Genesee

2021

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Nodular Lymphoma, lymphocytic — INTERVAL BETWEEN ONSET AND DEATH: 6 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1963, *to* Nov 25, 1967, *that I last saw the deceased alive on* Nov 22, 1967, *and that death occurred at* 10:30 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE Claude H. Weitz 691 (Degree or title) M.D.
23b. ADDRESS Pullman Washington
23c. DATE SIGNED 11-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-28-67
24c. NAME OF CEMETERY OR CREMATORY Moscow Cemetery
24d. LOCATION (City, town, or county) (State) Moscow, Latah Idaho

DATE REC'D BY LOCAL REG. 12-8-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER Fred J. Nelson — LICENSE NO. E-504
FIRM NAME: Short & Funeral Chapel Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DEC 19 1967
JUL 22 1968

SEP 13 1974
FEB 16 1977

Certificate of Death

STATE OF IDAHO

State File No. 5070
Local Reg. No. 156
Reg. Dist. No. 200

BIRTH NO. 67-11052 RECEIVED DEC 5 1967 4-05 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 5 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 290 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Viola
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Diane	Marie	Carlson	Nov	25	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	never married	Nov 25, 1967	0				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none 00		Moscow, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jimmy H. Carlson	Idaho	Velda Marshall	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	X Jimmy Harold Carlson	Viola, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity 776X — INTERVAL BETWEEN ONSET AND DEATH: 29 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 24, 1967, *to* Nov 25, 1967, *that I last saw the deceased alive on* Nov 25, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W Adams, OD	Moscow, Idaho	11/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 28, 1967	Viola Cemetery	Viola Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-1-67	Cheryl Ann Williams	Ronald Ward	E-80

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

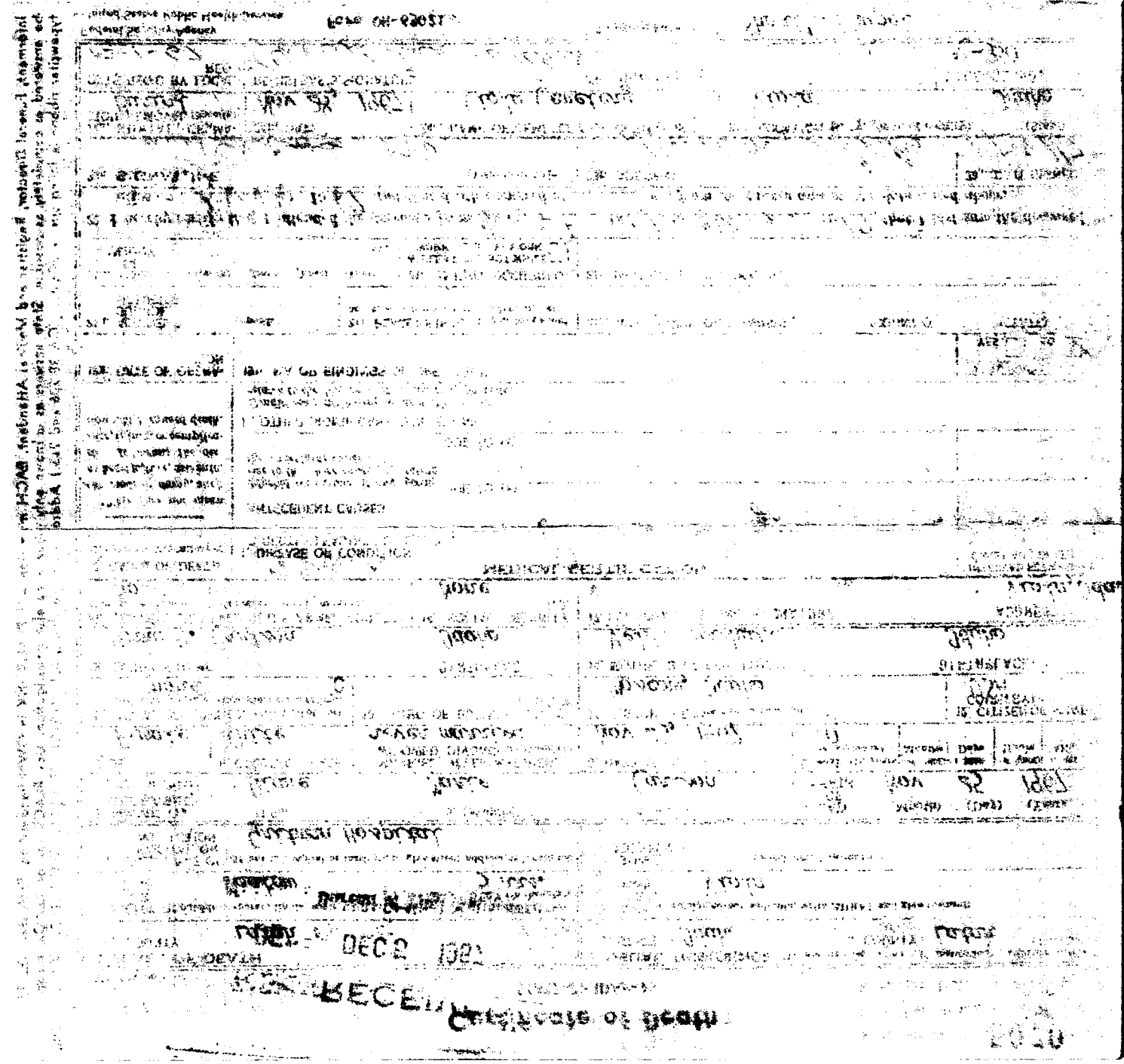

State File No. 5071
Local Reg. No. 159
Reg. Dist. No. 200

Certificate of Death

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 419 E. First St.

3. NAME OF DECEASED (Type or Print)
a. (First): Myrtle
b. (Middle): Verma
c. (Last): Davis

4. DATE OF DEATH (Month) (Day) (Year): Nov 27 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Jan 15, 1910
9. AGE (In years last birthday): 57 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Princeton, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lincoln Gilmore — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Yola Martin — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-09-5440
17. INFORMANT'S OWN SIGNATURE: X Emmett E. Davis — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5711

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bacterial Shock — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Acute Gastro-Enteritis — one day
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 1957, *to* Nov 27, 1967, *that I last saw the deceased alive on* Nov 27, 1967, *and that death occurred at* 9:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 001 (Degree or title): D. Adams, MD.
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 12/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 12-8-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Fred Nelson
LICENSE NO.: E-504

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

MAR 9 1973

NOV 26 1974

State File No. 5072
Local Reg. No. 160
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
c. LENGTH OF STAY (In this place) 3 Days 3-03
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Troy
d. STREET ADDRESS (If rural, give location) 112

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) Elizabeth c. (Last) Sundell

4. DATE OF DEATH (Month) (Day) (Year) November 30, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 8, 1895
9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Homemaker
11. BIRTHPLACE (State or foreign country) Troy, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Spencer BIRTHPLACE Kentucky
14. MOTHER'S MAIDEN NAME Mary Booth BIRTHPLACE Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-03-6663
17. INFORMANT'S OWN SIGNATURE X Theodore Sundell ADDRESS Troy, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1992

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA of Pelvis — INTERVAL BETWEEN ONSET AND DEATH unknown.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [X]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 1, 1967, *to* Nov. 30, 1967, *that I last saw the deceased alive on* Nov. 30, 1967, *and that death occurred at* 4:50 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE Omer H. Drury 148 (Degree or title) MD.
23b. ADDRESS Troy Idaho.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE 12-4-67
24c. NAME OF CEMETERY OR CREMATORY Burnt Ridge Cemetery
24d. LOCATION (City, town, or county) Troy Latah (State) Idaho

DATE REC'D BY LOCAL REG. 12-8-67
REGISTRAR'S SIGNATURE Cheryl Ann Williams
25. EMBALMER Donald Ward
LICENSE NO. E-380

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Short's Funeral Chapel Moscow, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

JAN 25 1968

State File No. 5073
Local Reg. No. 157
Reg. Dist. No. 200

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

DEC 7 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 290 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home at Genesee 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 290
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Frank
b. (Middle): H.
c. (Last): Wilson

4. DATE OF DEATH (Month) (Day) (Year): November 30, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 24, 1904
9. AGE (In years last birthday): 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pharmacist 21
10b. KIND OF BUSINESS OR INDUSTRY: Drug Store
11. BIRTHPLACE (State or foreign country): Genesee, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Milton Wilson — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Happie Mason — BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 533-01-7261
17. INFORMANT'S OWN SIGNATURE: × Esther M. Wilson — ADDRESS: Genesee, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5271

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): PULMONARY EMPHYSEMA — INTERVAL BETWEEN ONSET AND DEATH: yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 20, 1967, *to* Nov 30, 1967, *that I last saw the deceased alive on* Nov 10, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): John Bentley 013 MD
23b. ADDRESS: 307 St Johns Way
23c. DATE SIGNED: 12/2/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-2-67
24c. NAME OF CEMETERY OR CREMATORY: Genesee City Cemetery
24d. LOCATION (City, town, or county) (State): Genesee, Latah, Idaho

DATE REC'D BY LOCAL REG.: 12-6-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Fred J. Nelson
LICENSE NO.: E-504

FIRM NAME: Short's Funeral Chapel, Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DEC 8 1967

DEC 18 1967

Certificate of Death

STATE OF IDAHO

State File No. 5074
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO. 67-11070

RECEIVED NOV 22 1967

1. PLACE OF DEATH
a. COUNTY: Lemhi 300
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 300 Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Baby Girl (Carrie Dawn) b. (Middle) c. (Last) Holsinger

4. DATE OF DEATH: (Month) (Day) (Year) Nov. 2, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	never married	Oct. 31, 1967			2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salmon, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Holsinger — BIRTHPLACE: Colorado
14. MOTHER'S MAIDEN NAME: Maxine Fields — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no
17. INFORMANT'S OWN SIGNATURE: Mrs. Jay Cook — ADDRESS: Salmon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Premature birth — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): none
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-1-67, 19___, *to* 11-2-67, 19___, *that I last saw the deceased alive on* 11-2-67, 19___ *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 263 — 23b. ADDRESS: Salmon, Idaho — 23c. DATE SIGNED: 11-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 11-3-67 — 24c. NAME OF CEMETERY OR CREMATORY: Salmon — 24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Nov 10-67 — REGISTRAR'S SIGNATURE: Viola E. Johnson — 25. EMBALMER: [signature] — LICENSE NO.: E 369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 14 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5075
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 300 Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Tina b. (Middle) Gaynell c. (Last) Mullen

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 3, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug. 29, 1896

9. AGE (In years last birthday): 71 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Lemhi, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Solon Tobias — BIRTHPLACE: Vermont

14. MOTHER'S MAIDEN NAME: Ada Jane Gorton — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-26-2339

17. INFORMANT'S OWN SIGNATURE: Viola Edwards — ADDRESS: Salmon, Id

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Coronary — INTERVAL BETWEEN ONSET AND DEATH: 4201

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Occlusion — 0

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hypertension — 6 yr.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1961, 19__, *to* present, 19__, *that I last saw the deceased alive on* Nov 13, 1967, *and that death occurred at* 8 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. L. Blackadar MD 045 — **23b. ADDRESS**: Salmon, Idaho — **23c. DATE SIGNED**: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — **24b. DATE**: 11-6-67 — **24c. NAME OF CEMETERY OR CREMATORY**: Salmon — **24d. LOCATION** (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Nov-15-67 — **REGISTRAR'S SIGNATURE**: Viola E. Johnson

25. EMBALMER: Delbert H. Jones — **LICENSE NO.**: E 369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 27 1974

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
NOV 14 1967
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5076
Local Reg. No. 690
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
LENGTH OF STAY (in this place): 2 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 190 Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Challis (48 yrs.)
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Ollie b. (Middle) Jessie c. (Last) Connyers

4. DATE OF DEATH: (Month) (Day) (Year): Nov. 7, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: June 5, 1886

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Witchita, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jake Howick
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Hattie unknown
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: (husb.) 518-18-1775

17. INFORMANT'S OWN SIGNATURE: Clifton W Connyers
ADDRESS: Challis, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Cerebro Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with Hemiplegia — 3 mos
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

334X

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour): None m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1963, 19___, *to* Death 19___, *that I last saw the deceased alive on* 11-7, 1967, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. L. Blackadar MD 045
23b. ADDRESS: Salmon, Ida
23c. DATE SIGNED: 11-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-10-67
24c. NAME OF CEMETERY OR CREMATORY: Challis
24d. LOCATION (City, town, or county) (State): Challis, Idaho

DATE REC'D BY LOCAL REG.: Nov 10-67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Gilbert C Jones
LICENSE NO.: E 369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-69021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5077
Local Reg. No. 690
Reg. Dist. No.

RECEIVED NOV 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 1-23
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
LENGTH OF STAY (in this place): 23 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 300 Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location): Williams Creek

3. NAME OF DECEASED (Type or Print): a. (First) Richard b. (Middle) Charles c. (Last) Pape

4. DATE OF DEATH (Month) (Day) (Year): Nov. 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct. 15, 1881	86				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
businessman 19		Marietta, Ohio	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Pape	Ohio	Marj. Ellerford	Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	1902-1906 6	140 12 9795	Richard C. Pape, Jr.	Salmon, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Aortic Aneurysm	Unknown
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hypertension	3 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Osteoarthritis	15 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 3, 1967, *to* Nov 10, 1967, *that I last saw the deceased alive on* Nov 10, 1967, *and that death occurred at* 1:25A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ray D. Sinclair M.D.	Salmon Idaho	11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-13-67	Salmon	Salmon, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 25-67	Viola E. Johnson	Delbert C. Jones	E 369

FIRM NAME: Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 09 2000

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5078
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 1-35
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): 35 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 300 Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lemhi
d. STREET ADDRESS (If rural, give location): Whitson Ranch

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): Leslie
c. (Last): Whitson

4. DATE OF DEATH (Month) (Day) (Year): Nov. 20, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 28, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Grandview, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George L. Whitson — BIRTHPLACE: N. Dakota
14. MOTHER'S MAIDEN NAME: Blanche Rowe — BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-38-9984
17. INFORMANT'S OWN SIGNATURE: Walter B. Whitson — ADDRESS: Lemhi, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 0

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocardial Infarction 1d
DUE TO (c) Coronary occlusion 1d

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1950, 19__, *to* death, *that I last saw the deceased alive on* 11-19, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. Harhadar M.D. 045
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: 11-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-24-67.
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Dec 1st 67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C Jones — LICENSE NO. E 369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

OCT 23 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5079
Local Reg. No.
Reg. Dist. No.

RECEIVED DEC 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lewis 310 3-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Craigmont
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Glenn Tweedy home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Ore. 38
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Vale
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Margaret
b. (Middle): Ethelyn
c. (Last): Carnefix

4. DATE OF DEATH (Month) (Day) (Year): November 24, 1967

5. SEX: Female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 14, 1896
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Motel Manager 20
10b. KIND OF BUSINESS OR INDUSTRY: Motel
11. BIRTHPLACE (State or foreign country): New Berg Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles A. McBride — BIRTHPLACE: New Orleans, La.
14. MOTHER'S MAIDEN NAME: Idella Patterson — BIRTHPLACE: Cochocton Co., Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 464-62-4518
17. INFORMANT'S OWN SIGNATURE: Glenn C Tweedy — ADDRESS: Craigmont, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Philip C Clovis 583 Coroner, 4 Lewis County
23b. ADDRESS: Craigmont Idaho
23c. DATE SIGNED: 11-29-1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 29 1967
24c. NAME OF CEMETERY ~~OR CREMATORY~~: Prairie View
24d. LOCATION (City, town, or county) (State): Grangeville Idaho.

DATE REC'D BY LOCAL REG.: 11/30/69
REGISTRAR'S SIGNATURE: J. C. Clovis
25. EMBALMER: Clifford Nelson — LICENSE NO.: E421
FIRM NAME: Trenary Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 19 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 28 1998

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5080
Local Reg. No. 65
Reg. Dist. No. 430

Certificate of Death

RECEIVED
NOV 15 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320 1-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Richfield
c. LENGTH OF STAY (in this place): yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 320 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Richfield
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle):
c. (Last): BASE

4. DATE OF DEATH (Month) (Day) (Year): Nov. 9, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 24, 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months 0, Days 15 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: ——
11. BIRTHPLACE (State or foreign country): Chrast, Czechoslovakia
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert Base — BIRTHPLACE: Czechoslovakia
14. MOTHER'S MAIDEN NAME: Anna Kubicek — BIRTHPLACE: Czechoslovakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-42-5836
17. INFORMANT'S OWN SIGNATURE: X Elizabeth Base — ADDRESS: Richfield, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Cormary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-9-, 19 67, *to* _____, 19___, *that I last saw the deceased alive on* 1955 19___ *and that death occurred at* 10:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Marvin [signature] 285 M.D.
23b. ADDRESS: Box 237, Gooding, Idaho
23c. DATE SIGNED: 11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-13-1967
24c. NAME OF CEMETERY OR CREMATORY: Richfield Cemetery
24d. LOCATION (City, town, or county) (State): Richfield, Idaho

DATE REC'D BY LOCAL REG.: 11-14-67
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5081
Local Reg. No. 32
Reg. Dist. No. 630

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 331 000
b. CITY OR TOWN: Rexburg
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital 123

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 331 Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 221 West 2nd North Street

3. NAME OF DECEASED (Type or Print): a. (First) JAMES b. (Middle) RUDOLPH c. (Last) BISSETTE

4. DATE OF DEATH: (Month) (Day) (Year) November 4, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 28, 1921
9. AGE (In years last birthday): 46 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Service Station
11. BIRTHPLACE (State or foreign country): Bailey, North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James C. Bissette — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Martha Bissette — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War II
16. SOCIAL SECURITY NO.: 240-12-0424
17. INFORMANT'S OWN SIGNATURE: Sandra Bissette — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1965, *to* Nov, 1967, *that I last saw the deceased alive on* 11-4, 1967, *and that death occurred at* 7 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ray G. Mabey 317 (Degree or title) MD
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/8/67
24c. NAME OF CEMETERY OR CREMATORY: Sugar City
24d. LOCATION (City, town, or county) (State): Sugar City Madison Idaho

DATE REC'D BY LOCAL REG.: 11-7-67
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: James R Flamm — LICENSE NO.: E-477
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 23 2012

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5082
Local Reg. No. 53
Reg. Dist. No. 630

BIRTH NO.

RECEIVED NOV 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Madison 330
b. CITY OR TOWN (If outside corporate limits, write RURAL and township): Sugar City
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 330 Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sugar City
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Wendell	Deloss	Adamson	November 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	December 19, 1917	49				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Business Man 22	Restaurant	Shelley, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Deloss Adamson	American Fork, Utah	Pheobe Grace McMullen	Ledds, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-20-2032	Ruth S. Adamson	Sugar City, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Rt hod fusk coronary Thrombosis — 1954

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct. 1951, *to* Nov. 13, 1967, *that I last saw the deceased alive on* Nov. 13, 1967, *and that death occurred at* 10:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. J. Rigby 442 MD	Rexburg Idaho	Nov. 15 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/16/67	Shelley	Shelley Bingham Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-16-67	Lenna Flamm	Kenneth Flamm	E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5083
Local Reg. No. 54
Reg. Dist. No. 630

BIRTH NO.

RECEIVED NOV 2 1967 BUREAU OF VITAL STATISTICS

1-78

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (in this place): 78 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rexburg Best Home 307

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Madison 33
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Elizabeth	Jane Taylor	McEntire	November 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Cauc.	Widowed 2	December 4, 1865	101		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Ogden, Utah	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Pleasent Green Taylor Bowling Green, Kent.		Jane Narcissus Shurtliff Nauvoo, Illinois	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Raymond E McEntire	Rexburg, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Fundus of uterus
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
Feb 1966	N.A.C.	YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct, 1937, *to* Nov. 16, 1967, *that I last saw the deceased alive on* Nov. 15, 1967, *and that death occurred at* 4:00 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M.F. Bigler M.D. 442	Rexburg Idaho	11-17-1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/18/67	Grant Cemetery	Grant, Jefferson., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-18-67	Lorna Flamm	Russell Flamm	E-254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 9 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5084
Local Reg. No. 78
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 1 hour 4-01
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul
d. STREET ADDRESS (If rural, give location) 1050 west 50 south

3. NAME OF DECEASED (Type or Print)
a. (First) Betty
b. (Middle) Jane 125
c. (Last) Gibbs

4. DATE OF DEATH (Month) (Day) (Year) 11-2-67

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 10-14-1920

9. AGE (In years last birthday) 46 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stenographer 19

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Arcadia California

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Everett Lawrence — BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Minnie Lee Brown — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 557-12-5333

17. INFORMANT'S OWN SIGNATURE X D.R. Gibbs — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8164

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Skull fracture — INTERVAL BETWEEN ONSET AND DEATH 1 hr.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Automobile wreck

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) West of Rupert 06

21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 340 (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 11-2-67 7 a.m. 1

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Auto - auto wreck

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* Nov. 2, 1967, *and that death occurred at* 7:12 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE W. W. Crawford, M.D. 740 (Degree or title)

23b. ADDRESS Rupert, Idaho

23c. DATE SIGNED 11-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-4-1967

24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery

24d. LOCATION (City, town, or county) Paul (State) Idaho

DATE REC'D BY LOCAL REG. 11-6-67

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER Charles D Parsons — LICENSE NO. 494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 9 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 18 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5085
Local Reg. No. 77
Reg. Dist. No. 450

RECEIVED NOV 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340 — 4-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 1 hour

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 200 west 60 south

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Edna	125	Oliver	11-2-1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	11-11-1926	40				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cafe Operator 22		Rupert Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Freiburger	Ottoville Ohio	Anna Rausch	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-28-6144	X Robert C. Oliver Jr.	Rupert

8164

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hemorrhage and shock from severe laceration right lower extremity — INTERVAL BETWEEN ONSET AND DEATH: 1 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Automobile wreck.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident 1	West of Rupert 06	340 13

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Nov. 2, 1967 7a m. 1	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	Auto-auto wreck

22. *I hereby certify that I attended the deceased from* 1966, 19__, *to* Nov. 2, 1967, *that I last saw the deceased alive on* Nov. 2, 1967, *and that death occurred at* 8:10a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
740 W. W. Crawford, M.D.,	Rupert, Idaho	11-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11-6-1967	Rupert Cemetery	Rupert Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-6-67	Mary Ellen Carlson	Charles D. Parsons	494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 9 1967
NOV 10 1967
NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5086
Local Reg. No. 79
Reg. Dist. No. 450

RECEIVED
NOV 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340 1-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
c. LENGTH OF STAY (in this place): 7 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1831 I St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn
d. STREET ADDRESS (If rural, give location): 1831 I St.

3. NAME OF DECEASED (Type or Print)
a. (First): Martin
b. (Middle):
c. (Last): VanLishout

4. DATE OF DEATH (Month) (Day) (Year): Nov. 9 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 2, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: farming
11. BIRTHPLACE (State or foreign country): Green Bay, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Nelson VanLishout — BIRTHPLACE: Green Bay, Wis.
14. MOTHER'S MAIDEN NAME: Harriet Kuipers — BIRTHPLACE: Green Bay, Wis.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 502-05-2167
17. INFORMANT'S OWN SIGNATURE: Helen VanLishout — ADDRESS: Heyburn, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5271

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: undet.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Emphysema, severe — 15 yr.
DUE TO (c): Carcinoma, kidney — 5 month

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-16-, 1962, *to* 11-9-67, 19__, *that I last saw the deceased alive on* 10/23/67, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert M. Lovall Jr. MD, 506
23b. ADDRESS: Paul, Idaho
23c. DATE SIGNED: 11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/13/67
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Heyburn Idaho

DATE REC'D BY LOCAL REG.: 11-17-67
REGISTRAR'S SIGNATURE: Mary Ellen Carlson
25. EMBALMER: Garth Adyne
LICENSE NO.: E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5087
Local Reg. No. 82
Reg. Dist. No. 450

BIRTH NO.

RECEIVED NOV 24 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka 340 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 323 east 3rd street

3. NAME OF DECEASED (Type or Print): a. (First) Linwood b. (Middle) Abel 125 c. (Last) Evans

4. DATE OF DEATH: (Month) (Day) (Year): 11-16-1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 10-13-1894

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Gardner 06

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Spanish Fork Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edward Abel Evans
BIRTHPLACE: Lehi Utah

14. MOTHER'S MAIDEN NAME: Eva Christine Ottesen
BIRTHPLACE: Spanish Fork Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-14-0011

17. INFORMANT'S OWN SIGNATURE:
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage 331X — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct, 1967, *to* Nov 16, 1967, *that I last saw the deceased alive on* 11-16, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: T. A. Hunt MD
255 (Degree or title)

23b. ADDRESS: Rupert, Idaho

23c. DATE SIGNED: 11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov 20 1967

24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery

24d. LOCATION (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: 11-21-67

REGISTRAR'S SIGNATURE: Mary Ellen Carlson

25. EMBALMER: Charles L Parsons

LICENSE NO.: 494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

MAY 27 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5088
Local Reg. No. 81
Reg. Dist. No. 450

Certificate of Death

STATE OF IDAHO

BIRTH NO.

NOV 24 1967 Bureau of Vital Statistics

1-05

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorail Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) J Street

3. NAME OF DECEASED (Type or Print)
a. (First) Althear
b. (Middle) Burdette 125
c. (Last) Gregory

4. DATE OF DEATH (Month) (Day) (Year) Nov 16 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 28 1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Andover Ohio
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry George Eaton — BIRTHPLACE Pennsylvania
14. MOTHER'S MAIDEN NAME Kate Amelia Spaulding — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 518-60-8535
17. INFORMANT'S OWN SIGNATURE James D. Parkinson — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4222

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocarditis.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Old Age.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1958, *to* Nov 16, 1967, *that I last saw the deceased alive on* Nov 16, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE R. A. Amordsen 365 (Degree or title)
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov 20 1967
24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery ~~Rupert Cemetery~~
24d. LOCATION (City, town, or county) (State) Pocatello Idaho

DATE REC'D BY LOCAL REG. 11-21-67
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Charles H. Persons
LICENSE NO. 494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5089
Local Reg. No. 80
Reg. Dist. No. 450

BIRTH NO.

RECEIVED NOV 24 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340 3-02
b. CITY OR TOWN Rupert
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 160 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) (Jackson Area) near Rupert
d. STREET ADDRESS (If rural, give location) Rural route 1 Rupert Idaho

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle) 125	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Claude	Roy	Littleton	Nov 20 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 20 1904	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Tennessee
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME BIRTHPLACE Jacob Littleton-Green County Tenn
14. MOTHER'S MAIDEN NAME BIRTHPLACE Hannah Moore unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 479-12-4268
17. INFORMANT'S OWN SIGNATURE Vaun Littleton ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4222 Myo cardeb. — INTERVAL BETWEEN ONSET AND DEATH 2 years.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hemiplegia 5 years ago
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Rupert Minidoka Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 1965, *to* Nov 20, 1967, *that I last saw the deceased alive on* Nov 20, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 3605	M.D.	Rupert Idaho	11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	11-22-1967	Twin Falls Cemetery	Twin Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-21-67	Mary Ellen Barlow	Charles H Parsons	494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

State File No. 5090
Local Reg. No. 85
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1005 Eighth Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 340
b. COUNTY: Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 708 "F" Street

3. NAME OF DECEASED (Type or Print): a. (First) Mabel b. (Middle) Irene c. (Last) PARKER

4. DATE OF DEATH (Month) (Day) (Year): November 25, 1967

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Sept. 11, 1893

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Clinton, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Earl Henson
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Grace Mabel Brown
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-30-9200

17. INFORMANT'S OWN SIGNATURE: x Mrs Parker
ADDRESS: Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart failure 4331
INTERVAL BETWEEN ONSET AND DEATH: 10 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Arterial Fibrillation 5 years duration

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 62, 19__, to Nov 24 62, 1967, that I last saw the deceased alive on Nov 24 62, 1967, and that death occurred at 3 P m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] 365 (Degree or title) M.D.
23b. ADDRESS: Rupert Idaho
23c. DATE SIGNED: 11-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: 12-1-67
REGISTRAR'S SIGNATURE: Mary Ellen Barker
25. EMBALMER: Charles L. Parsons
LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 5 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5091
Local Reg. No. 83
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 7 weeks

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert (Route 1, rural)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital
d. STREET ADDRESS (If rural, give location) Route 1, East 1st Street

3. NAME OF DECEASED (Type or Print) a. (First) Willie b. (Middle) 125 Wesley c. (Last) GIBSON

4. DATE OF DEATH (Month) (Day) (Year) November 25, 1967

5. SEX Male
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 24, 1888
9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer
10b. KIND OF BUSINESS OR INDUSTRY 04 Agriculture
11. BIRTHPLACE (State or foreign country) Dutch Mills Tnsp., Arkansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Wesley Gibson BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Henrietta Beaver BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 519-03-1032
17. INFORMANT'S OWN SIGNATURE Edith Ramsey ADDRESS Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1557 Carcinoma of ~~stomach~~ Pancreas. — INTERVAL BETWEEN ONSET AND DEATH: 1 year.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Biliary obstruction — 6 months.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1964 *to* Nov 25, 1967, *that I last saw the deceased alive on* Nov 25, 1967 *and that death occurred at* 11:50a m., *from the causes and on the date stated above.*

23a. SIGNATURE 365 (Degree or title)
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 11-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 27, 1965
24c. NAME OF CEMETERY OR CREMATORY Rupert Cametery
24d. LOCATION (City, town, or county) Rupert, Idaho (State)

DATE REC'D BY LOCAL REG. 11-29-67
REGISTRAR'S SIGNATURE Mary Ellen Gaskin
25. EMBALMER Charles L. Parsons
LICENSE NO. E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5092
Local Reg. No.
Reg. Dist. No.

RECEIVED STATE OF IDAHO

BIRTH NO.

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka (340) DEC 5 1967 3-03
b. CITY OR TOWN: Rupert
c. LENGTH OF STAY IN this place: 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: (340) Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 909 Sixth Street

3. NAME OF DECEASED (Type or Print)
a. (First): Bessie
b. (Middle): 125
c. (Last): Kilbourn BURGHER

4. DATE OF DEATH (Month) (Day) (Year): November 27, 1967

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Nov. 25, 1876

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Porterville, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Ely Kilbourn
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Sophronia Stoddard
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-54-2024

17. INFORMANT'S OWN SIGNATURE: Patricia Ann Burgher
ADDRESS: House

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9039

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Internal hemorrhage
INTERVAL BETWEEN ONSET AND DEATH: hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Complications resulting from
DUE TO (c): fall that produced fract Rt hip

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-24, 1967, *to* 11-27, 1967, *that I last saw the deceased alive on* 11-27, 19 67, *and that death occurred at* 12:53 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 253 Ben K. Humphrey MD #1

23b. ADDRESS: 645-5th St Rupert Ida

23c. DATE SIGNED: 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 30, 1967

24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery

24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: 11-29-67

REGISTRAR'S SIGNATURE: Mary Ellen Carlson

25. EMBALMER: Charles D. Persons

LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5093
Local Reg. No. 87
Reg. Dist. No. 452

RECEIVED DEC 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Paul (Rural)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 500 West-050 South

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 161 Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 827 Schodde Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	John	Albert	KENDALL	November 29, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married 3	Nov.26,1913	54				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Laborer 04	Agriculture	Rawlins, Wyoming	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Hyrum Kendall	Utah	Dora Holms	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - - - -	520-07-0841	Mrs Edith Kendall	Burley, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral contusion, recent, involving cerebral cortex, bilateral, internal capsular area, bilateral ands pons verolli. duration, minutes to hour.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Abrasions on head and torso, recent.

DUE TO (c) Cardiac hypertrophy, left and right, duration, years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Sugar Factory 03	Paul, Minidoka County, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
Nov 29 1967-12:45 AM	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	hit by train engine, fell into flume.

22. *I hereby certify that I attended the deceased from* did not see alive, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
583 Robert C Walk	Coroner	710 6th street Rupert Idaho	Nov 30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec.1,1967	Riverside Cemetery	Heyburn, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 4 1967	Mary Ellen Larson	Charles L Parsons	E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 13 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. AUG 16 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5094
Local Reg. No. 257
Reg. Dist. No. 220

BIRTH NO. 67-10228

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 .000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1107 Cedar Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): TERRY
b. (Middle): LYNN
c. (Last): COY

4. DATE OF DEATH (Month) (Day) (Year): 25 October 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: 25 October 1967
9. AGE (In years last birthday): - - - -
IF UNDER 1 YEAR: Months - - Days - -
IF UNDER 24 HRS.: Hours 5 Min. 49

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Francis Coy
BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Carol Scoles
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Francis W. Coy
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7625

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Atelectasis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 25, 1967, *to* Oct 25, 1967, *that I last saw the deceased alive on* Oct 25, 1967, *and that death occurred at* 11:55 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert L Olson 397 M.D.
23b. ADDRESS: 324 Fifth St, Lewiston
23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 30 Oct 1967
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-9-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L. E. DeBaun
Malcom's Brower-Wannn Memo. Chapel
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5095
Local Reg. No. 255
Reg. Dist. No. 220

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 351 1-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
STAY (in this place): 3yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchard Nurssing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 351 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1014- Burell

3. NAME OF DECEASED (Type or Print): a. (First) Edward; b. (Middle) C.; c. (Last) Anderson

4. DATE OF DEATH (Month) (Day) (Year): Oct 31, 1967

5. SEX: male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: Nov 4, 1883

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR — Months / Days
IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor Retired 06

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Helena, Mont.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert Anderson
BIRTHPLACE: Sweeden

14. MOTHER'S MAIDEN NAME: Margaret Bowen
BIRTHPLACE: Minn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE: Mrs Myrtle Taylor
ADDRESS: Lewiston, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Infirmitas of age

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* ____, 19__, *that I last saw the deceased alive on* Oct 30, 1967, *and that death occurred at* 4:40P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ron Glover, 507 (Degree or title)
23b. ADDRESS: 939 Bryden Ave.
23c. DATE SIGNED: 11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 3, 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 11-7-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Andrew F. Vassar
LICENSE NO.: E 315

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5096
Local Reg. No. 260
Reg. Dist. No. 220

RECEIVED NOV 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 35 — 2-01
b. CITY OR TOWN: Lewiston
(c) LENGTH OF STAY: 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 909 - 6th Street

3. NAME OF DECEASED (Type or Print)
a. (First): MILDRED
b. (Middle): NORMA
c. (Last): UHLENKOTT

4. DATE OF DEATH: (Month) 1 November (Day) (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 22 March 1912
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Cottonwood, Idaho
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: Jess McKinley — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Bertha Wortman — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 36 1689
17. INFORMANT'S OWN SIGNATURE: A. D. Uhlenkott — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible] 19 64, *to* 10 31, 19 67, *that I last saw the deceased alive on* 10 31, 19 67, *and that death occurred at* 12:33 AM, *from the causes and on the date stated above.*

23a. SIGNATURE: L. Cusmon 114 (Degree or title): M. D.
23b. ADDRESS: 347 S. Johns Way
23c. DATE SIGNED: 11 3 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 3 Nov 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-14-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: K. H. Malcom — Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-376

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 7 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 30, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5097
Local Reg. No. 254
Reg. Dist. No. 220

BIRTH NO. 3-05

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: 555 Garfield
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pomeroy
d. STREET ADDRESS (If rural, give location): Rural- Van Natton Grade

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	NICHOLAS	C.	ROBERTSON		11	1	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Never Married	6-10-1943	24		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 64	Wheat Farm	Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Billie Robertson	Pomeroy Wash.	Betty Young	Pomeroy Wash.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Billie Kenneth Roberton	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7441

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardiopathy. — INTERVAL BETWEEN ONSET AND DEATH: 6 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Muscular dystrophy. — 15+ yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Probable cerebral embolism. — 5 days.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May. 19 67 *to* Nov. 19 67, *that I last saw the deceased alive on* Nov. 1. 19 67, *and that death occurred at* 8a m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B R Stein 496	M D,	Lewiston Idaho	3 Nov 67.

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	11-3-1967	City	Pomeroy, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
11-6-67	Lynette Knott	Richardson Funeral Home- Andy Reinland, Jr.	Pomeroy, Wash.

Federal Security Agency
United States Public Health Service

Form DPH-40021

NOV 1 5 1991

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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State File No. 5098
Local Reg. No. 256
Reg. Dist. No. 220

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 2-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 3 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 13 Idaho
b. COUNTY: 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 909 Preston Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): ORIL
b. (Middle): EUGENE 312
c. (Last): TUETH

4. DATE OF DEATH (Month) (Day) (Year): 2 November 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 28 August 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nurseryman 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Mayview, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Tueth — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Sarah Booth Newkirk — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 09 4185
17. INFORMANT'S OWN SIGNATURE: Helen Huett — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1930

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Thioma of brain — INTERVAL BETWEEN ONSET AND DEATH: 8 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 July, 1967, *to* 2 Nov, 1967, *that I last saw the deceased alive on* 2 Nov, 1967, *and that death occurred at* 3:30 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Bernard Shreyward MD 229
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 6 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 6 Nov. 1967
24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-9-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: K. H. Malcom — LICENSE NO.: E-376
Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5099
Local Reg. No. 259
Reg. Dist. No. 220

RECEIVED NOV 28 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nezperce 350
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Genesee - Rural
LENGTH OF STAY (at this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Genesee - Rural 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: 555 Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 504 18th Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Jerry	Lee	Landrus		11	3	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
M	W	M 3	3-13-44	23		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sawmill worker 17	Lumbering	Lewiston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Neal Landrus	Potlatch, Idaho	Elizabeth Peer	Reubens, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	1965 - 67 8	531-42-4939	Diane Landrus	Clarkston, Wash.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock + Hemorrage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Injuries
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	06	5 Miles No of Top of Lewiston Hill 350

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
11-3-67 4:30 A.M.		Auto Accident

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 4:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wilfred J. Deuel	583 Coroner 4	Lewiston Idaho	11-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal B	11-6-67	Vineland	Clarkston, Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-13-67	Lynette Knott	Robert Sarsfield	Oh 802

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Merchant Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 29 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 16 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5100
Local Reg. No. 261
Reg. Dist. No. 220

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 350 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spalding
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Spalding (rural)
d. STREET ADDRESS (If rural, give location): Rt. 1, Box 397

3. NAME OF DECEASED (Type or Print): a. (First) BERNADINE b. (Middle) DIANNE c. (Last) GREENE

4. DATE OF DEATH: (Month) 4 November (Day) (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Indian	Married 3	11 Sept 1940	27		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Lenore, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
A. M. Pinkham	Idaho	Annette Blackeagel	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	541 42 2093	Priscilla Henry	Lenore, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Massive hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) incomplete abortion — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
none	none	YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
accident,	none 01	Spalding 3 none Nez Perce 350 Idaho	none m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	none

22. *I hereby certify that I attended the deceased from* - - - - - *, 19* - - *, to* - - - - - *, 19* - - *, that I last saw the deceased alive on* - - - - - *, 19* - - *; and that death occurred at* 8:30 AM. *, from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
090 PATHOLOGIST	1225 Hazeland Ave Clarkston, Wn	4 Nov 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	8 Nov 1967	Coyote Cemetery (Indian)	rural NezPerce Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-14-67	Lynette Knott	W. E. Black	E-426

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 22 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5101
Local Reg. No. 263
Reg. Dist. No. 220

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

NOV 28 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 351 NezPerce 201

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston

c. LENGTH OF STAY (in this place) 18 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE 13 Idaho 351

b. COUNTY Nez Perce

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston

d. STREET ADDRESS (If rural, give location) 414 - 14th Street

3. NAME OF DECEASED (Type or Print)

a. (First) ELMER

b. (Middle) ORRIN

c. (Last) FALES

4. DATE OF DEATH (Month) (Day) (Year) 7 Nov. 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 23 Sept 1890

9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04

10b. KIND OF BUSINESS OR INDUSTRY Stock & Grain

11. BIRTHPLACE (State or foreign country) Loop Co., Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Amos E. Fales — BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Esther Ann Gifford — BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 507 10 6684

17. INFORMANT'S OWN SIGNATURE Mrs Blanche Fales — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH 2041

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Onsquend Anemia — INTERVAL BETWEEN ONSET AND DEATH 2 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Myelogenous Leukemia — 4 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on* Nov 7th, 1967, *and that death occurred at* 9:52 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE Joseph E Boedigh M.D. 022 (Degree or title)

23b. ADDRESS 1522 17th St City

23c. DATE SIGNED 11/10/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10 Nov 1967

24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 11-14-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel

LICENSE NO. E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5102
Local Reg. No. 262
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY 351 Nez Perce NOV 28 1967 302

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Bureau of Vital Statistics

c. LENGTH OF STAY (If in hospital or institution, give street address or location) 2 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 351 b. COUNTY Nez Perce

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston

d. STREET ADDRESS (If rural, give location) 3405 - 4th Street 'D'

3. NAME OF DECEASED (Type or Print)

a. (First) ELIZABETH (Betty) b. (Middle) DORIS c. (Last) ANDERSON

4. DATE OF DEATH (Month) (Day) (Year) 7 November 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 25 May 1922

9. AGE (In years last birthday) 45 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Palouse, Washington

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Oril E. Tueth BIRTHPLACE Mayfield, Wash.

14. MOTHER'S MAIDEN NAME Marie Oldenburg BIRTHPLACE Minneapolis, Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. No Record

17. INFORMANT'S OWN SIGNATURE Gwyn Anderson ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

330X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~Rupt~~ Cerebral Hemorrhage

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Ruptured Congenital Aneurysm

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9 14, 1967, *to* 10 7, 1967, *that I last saw the deceased alive on* 6 Pk, 1967, *and that death occurred at* 9:23 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Hussmer 114 (Degree or title)

23b. ADDRESS 1342 St John Way

23c. DATE SIGNED 11 12 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11 Nov 1967

24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 11-14-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER L. E. DeBaun Malcom's Brower-Wann Memorial Chapel

LICENSE NO. E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5103
Local Reg. No. 264
Reg. Dist. No. 220

RECEIVED NOV 28 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 201
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY IN (this place) 3 WKS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 29
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kendrick
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE CHRISTIAN
b. (Middle) ALBERT
c. (Last) WILKEN

4. DATE OF DEATH (Month) (Day) (Year) 8 November 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 16 July 1899

9. AGE (In years last birthday) 68
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Stock & Grain

11. BIRTHPLACE (State or foreign country) Cameron, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Herman Wilken
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Emilie Hettmeier
BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 14 5409

17. INFORMANT'S OWN SIGNATURE Margaret M Kerbrat
ADDRESS Venice Calif

18. CAUSE OF DEATH 4288
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pulmonary Infarction. — INTERVAL BETWEEN ONSET AND DEATH: 15+ days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease, failure — 10+ years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1958 *to* 8 Nov., 1967, *that I last saw the deceased alive on* 8 Nov., 1967, *and that death occurred at* 10:50 AM, *from the causes and on the date stated above.*

23a. SIGNATURE B C Stein 496 (Degree or title) MD

23b. ADDRESS Lewiston Idaho

23c. DATE SIGNED 10 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 10 Nov 1967

24c. NAME OF CEMETERY OR CREMATORY Cameron Cemetery

24d. LOCATION (City, town, or county) (State) Cameron, NezPerce, Idaho

DATE REC'D BY LOCAL REG. 11-14-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER L E DeBaun
Malcom's Brower-Wann Memorial Chapel

LICENSE NO. E-295

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 4 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 3 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5104
Local Reg. No. 267
Reg. Dist. No. 220

BIRTH NO.

NOV 28 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 357 Nez Perce 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington b. COUNTY 555 Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Clarkston
d. STREET ADDRESS (If rural, give location) 409 - 6th Street

3. NAME OF DECEASED (Type or Print): a. (First) ALBERT b. (Middle) EDWARD c. (Last) KIDDER

4. DATE OF DEATH: (Month) (Day) (Year) 9 November 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 18 April 1902
9. AGE (In years last birthday): 65 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Powderman 11
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Emmett Co., Michigan
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Nahum A. Kidder — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Mary A. Mercer — BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 544-07-5978
17. INFORMANT'S OWN SIGNATURE Dorothy M. Kidder — ADDRESS Clarkston, Wash.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION — INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — Days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Myocardial Infarction — 3 yrs

DUE TO (c) Coronary Atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Bronchial Asthma

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/12, 1967 *to* 11/8, 1967, *that I last saw the deceased alive on* 11/8, 1967, *and that death occurred at* 12:01 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 5/2 — 23b. ADDRESS Lewiston, Idaho — 23c. DATE SIGNED 11/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 13 Nov 1967
24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery
24d. LOCATION (City, town, or county) (State) Orofino, Clearwater Co., Idaho

DATE REC'D BY LOCAL REG. 11-17-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER L. E. DeBaun — LICENSE NO. E-295
Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

DUTIES:

NOV 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 12 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5105
Local Reg. No. 265
Reg. Dist. No. 220

Certificate of Death

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 206
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 6 Mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1307 G Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 13 Idaho
b. COUNTY 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1307 G Street

3. NAME OF DECEASED (Type or Print)
a. (First) Michelle
b. (Middle) Rene
c. (Last) Finney

4. DATE OF DEATH (Month) (Day) (Year) Nov. 10, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH May 9, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months 6 Days 1 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 02
10b. KIND OF BUSINESS OR INDUSTRY none
11. BIRTHPLACE (State or foreign country) Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME David Finney
BIRTHPLACE Oklahoma
14. MOTHER'S MAIDEN NAME Jerretta Legate
BIRTHPLACE Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE David L Finney
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

0534

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable FULMINATING INFECTION

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from ----------, 19---, to --- ---, 19---, that I last saw the deceased alive on ------, 19--, and that death occurred at* 2:30PM, *from the causes and on the date stated above.*

23a. SIGNATURE Wilford J Duclos 583 (Degree or title) coroner 4
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED 11/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 1
24b. DATE Nov. 15, 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 11-15-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER V. Vassar
LICENSE NO. E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: D-67-4805

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5106
Local Reg. No. 274
Reg. Dist. No. 220

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35/ Nez Perce
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 35/
b. COUNTY Nez Perce
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) 0212 - 26th Street

3. NAME OF DECEASED (Type or Print)
a. (First) ADOLPH
b. (Middle) EMIEL
c. (Last) GIESE

4. DATE OF DEATH (Month) (Day) (Year) 12 Nov. 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH 12 Dec. 1904

9. AGE (In years last birthday) 62
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Stock & Grain

11. BIRTHPLACE (State or foreign country) Juliaetta, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Julius Giese
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Susana Dennler
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW-2 4

16. SOCIAL SECURITY NO. 543 24 0023

17. INFORMANT'S OWN SIGNATURE Elmer Giese
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4211

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Aortic Seterosis — INTERVAL BETWEEN ONSET AND DEATH: no record

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* - - - - - -, 19- -, *to* - - - - - -, 19- -, *that I last saw the deceased alive on* - - - - - -, 19- -, *and that death occurred at* 5:30 PM., *from the causes and on the date stated above.*

23a. SIGNATURE Herbert L. DeBaun 583 (Degree or title) Nez Perce Co. Coroner

23b. ADDRESS 2130 Sunset Dr., Lewiston, Ida.

23c. DATE SIGNED 12 Nov '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 16 Nov 1967

24c. NAME OF CEMETERY OR CREMATORY Fix Ridge Cemetery

24d. LOCATION (City, town, or county) (State) Juliaetta, Latah Co., Idaho

DATE REC'D BY LOCAL REG. 11-22-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER L. E. DeBaun

LICENSE NO. E-295

Malcom's Brower-Wann Memorial Chapel

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5107
Local Reg. No. 269
Reg. Dist. No. 220

Certificate of Death

RECEIVED
DEC 1 1 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 309
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (If not in place) 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 406 Park Drive

3. NAME OF DECEASED (Type or Print)
a. (First) BOYER
b. (Middle) AKIM
c. (Last) NILSON

4. DATE OF DEATH (Month) (Day) (Year) 14 November 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 1 Sept 1900
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04
10b. KIND OF BUSINESS OR INDUSTRY Stock & Grain
11. BIRTHPLACE (State or foreign country) Aberdeen, South Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Nils M. Nilson — BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Marie Paulson — BIRTHPLACE So. Dak.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 42 3397
17. INFORMANT'S OWN SIGNATURE Mrs Boyer Nilson — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) AORTIC STENOSIS — INTERVAL BETWEEN ONSET AND DEATH Yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Rheumatic Heart Disease — yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Apr 1965, *to* November, 1967, *that I last saw the deceased alive on* Nov 14, 1967, *and that death occurred at* 3:40 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE John, Arms Roz Mrs 013 (Degree or title)
23b. ADDRESS 307 St. John's Way
23c. DATE SIGNED 11/16/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 18 Nov 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 11-21-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER L E DeBaun — LICENSE NO. E-295
Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 1 5 1990

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5108
Local Reg. No. 266
Reg. Dist. No. 220

RECEIVED
NOV 28 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
LENGTH OF STAY (in this place) 1 WK
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 35
b. COUNTY Nez Perce 7
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1430 8th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ERIC	HAROLD	ERICKSON	14 November 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	20 July 1905	62				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Wholesale 21	Plumbing	Sweden	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Emil Erickson	Sweden	Anna Louise Olson	Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		533 01 9349	Mrs Elmore Erickson	Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1444X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer Mouth — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept. 5, 19 67 *to* Nov 14, 1967, *that I last saw the deceased alive on* NOV 14, 1967, *and that death occurred at* 12:55 PM *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
036 (Degree or title)	626 5th Ave, Lewiston, Ida	11/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	17 Nov 1967	Riverside Memo. Park	Spokane, SpokaneCo., Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-17-67	Lynette Knott	L. E. DeBaun	E-295

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5109
Local Reg. No. 270
Reg. Dist. No. 220

RECEIVED DEC 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 1 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 2019 Grelle Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DAISY	MAE	BRODHEAD	16 November 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	12 March 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Fremont, Iowa	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eli Pearson	no record	Alice Saruas	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 14 4146	Mrs Ray Mitchell	Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1807 adeno carcinoma Rt Kidney — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11/14/67	Inoperable carcinoma Rt. Kidney	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10-10, 1967, *to* 10-19, 1967, *that I last saw the deceased alive on* 10-19, 1967, *and that death occurred at* 8:30 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
John F. Barnes M.D. 028		3475 Thain Way Lewiston Idaho	11-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	18 Nov 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-21-67	Lynette Knott	L. E. DeBaun Malcom's Brower-Wann Memorial Chapel	E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

.....

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State File No. 5110
Local Reg. No. 268
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

DEC 11 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 351 Nez Perce 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
c. LENGTH OF STAY (If outside place): 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 504-6th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Edward
b. (Middle): E.
c. (Last): Moen

4. DATE OF DEATH (Month) (Day) (Year): Nov. 17, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: March 16, 1967
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber worker 17
10b. KIND OF BUSINESS OR INDUSTRY: Sawmill
11. BIRTHPLACE (State or foreign country): Norway
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: no record — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: no record
17. INFORMANT'S OWN SIGNATURE: Mrs. Ed Moen — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

022X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 da

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Severe malnutrition — 1 yr.
DUE TO (c): Aortic aneurysm — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 2:30 a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 160
23b. ADDRESS: Lewiston Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Nov. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-20-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: V. Vassar
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

English

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 18 1967

SEP 16 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5111
Local Reg. No. 272
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 351 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston,
d. STREET ADDRESS (If rural, give location) Orchards Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First) MATILDA
b. (Middle) NMI
c. (Last) THOMPSON

4. DATE OF DEATH (Month) (Day) (Year) 17 Nov 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 17 July 1877
9. AGE (In years last birthday) 90 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper OX
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Gilmokra, Sweden
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME No Record — BIRTHPLACE Sweden
14. MOTHER'S MAIDEN NAME No Record — BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 60 9942
17. INFORMANT'S OWN SIGNATURE Attavene Blakeman — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Heart Attack — 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic H. Dis. — 20 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Stroke

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1957, 19__, *to* 11 17, 1967, *that I last saw the deceased alive on* 11 17, 1967 *and that death occurred at* 11:20AM *m., from the causes and on the date stated above.*

23a. SIGNATURE L. Cummins 114 (Degree or title) MD
23b. ADDRESS St. Mary Way Lewiston
23c. DATE SIGNED 11 20 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 21 Nov 1967
24c. NAME OF CEMETERY OR CREMATORY I.O.O.F Cemetery
24d. LOCATION (City, town, or county) (State) Craigmont, Lewis Co., Idaho

DATE REC'D BY LOCAL REG. 11-21-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5112
Local Reg. No. 276
Reg. Dist. No. 220

Certificate of Death

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 350 Nes Perce 104
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston (Rural)
c. LENGTH OF STAY (in this place) 4yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchard Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 310 Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Craigmont
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Bruno
b. (Middle) C.
c. (Last) Laufer

4. DATE OF DEATH (Month) (Day) (Year) Nov. 18 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH March 3 1886
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Eitzen, Minn.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Conrad Laufer — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Mary — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-42-2919
17. INFORMANT'S OWN SIGNATURE Capitola Willson — ADDRESS Reubens, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 2:04 p. m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 051 (Degree or title) MD
23b. ADDRESS LEWISTON, IDAHO
23c. DATE SIGNED 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memorial Gardens
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho.

DATE REC'D BY LOCAL REG. 11-29-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar
LICENSE NO. E-315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 17 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 4 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5113
Local Reg. No. 271
Reg. Dist. No. 220

RECEIVED DEC 11 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 3327 Bryden Court

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	GEORGE	OSCAR	APPLE	20 November 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	28 April 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Stock & Grain	Cookeville, Tenn.	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Apple	No Record	Matilda Ferrell	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	517 40 4735	Frieda M. Apple	Lewiston, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 5 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Nov 1 *19* 67 *to* Nov 20 *, 19* 67 *that I last saw the deceased alive on* Nov. 17 *, 19* 67 *, and that death occurred at* 8:45 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	021	625 6th Ave	Nov 30, 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	21 Nov 1967	Creel Funeral Home	Lewistown, Fergus Co., Mont.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-21-67	Lynette Knoll	L E DeBaun — Malcom's Boower-Wann Memorial Chapel	E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

DUTIES:

DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 22 1967

Certificate of Death

STATE OF IDAHO

State File No. 5114
Local Reg. No. 287
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce — 09 112
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 12yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 3632 - 21 st.

3. NAME OF DECEASED (Type or Print) a. (First) Violet b. (Middle) Ruth c. (Last) Paulson

4. DATE OF DEATH (Month) Nov. (Day) 20 (Year) 1967

5. SEX: F
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 10, 1907
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Condon, Oregon
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edmond Chochrane — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Meda Rogers — BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Ray W. Paulson — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 20, 1967, *to* Nov 20, 1967, *that I last saw the deceased alive on* Nov 20, 1967, *and that death occurred at* 4:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ron Brower MD — 507 (Degree or title)
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 12-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 22 July 1967
24c. NAME OF CEMETERY OR CREMATORY: Vineland
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 12-6-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L.E. DeBaun — LICENSE NO. E-295
FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5115
Local Reg. No. 273
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nezperce 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 17 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 180
b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Teakean
d. STREET ADDRESS (If rural, give location) Unknown

3. NAME OF DECEASED (Type or Print)
a. (First) Raymond
b. (Middle) G.
c. (Last) Blankenship

4. DATE OF DEATH (Month) (Day) (Year) November 20, 1967

5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 2, 1899
9. AGE (In years last birthday) 68 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Troy Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Blankenship — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Nancy Kerns — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-12-965 ~~No Record~~ B3A
17. INFORMANT'S OWN SIGNATURE Edith Blankenship — ADDRESS Lenore, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5271

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Purulent Pericarditis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Kleibacillus
DUE TO (c) "Pneumonia Emphysema

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Arthritis, hypoadrenalism, Osteoporosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 22, 1967, *to* 11 19, 1967, *that I last saw the deceased alive on* 11 19, 1967, *and that death occurred at* 6 20 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE Hummer 114 (Degree or title) M.D.
23b. ADDRESS 342 St Johns Way
23c. DATE SIGNED 11 21 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11/22/67
24c. NAME OF CEMETERY OR CREMATORY Vineland Cemetery
24d. LOCATION (City, town, or county) (State) Clarkston, Washington

DATE REC'D BY LOCAL REG. 11-21-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Robert Larrabee
LICENSE NO. OL 802

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Merchant Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 2 9 1995

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5116
Local Reg. No. 282
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

DEC 1 1 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: 351 Nez Perce 302

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

c. LENGTH OF STAY (If in hospital or institution): 2 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 351

b. COUNTY: Nez Perce

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston

d. STREET ADDRESS (If rural, give location): 312 - 11th Ave.

3. NAME OF DECEASED (Type or Print)

a. (First): JAMES

b. (Middle): SAMUEL

c. (Last): NEWTON

4. DATE OF DEATH (Month) (Day) (Year): 22 Nov. 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 11 Feb 1905

9. AGE (In years last birthday): 62 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician & Surgeon 14

10b. KIND OF BUSINESS OR INDUSTRY: Medicine

11. BIRTHPLACE (State or foreign country): Concord, Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Archiebald Newton — BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Maude Cheroweth — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW-2 4

16. SOCIAL SECURITY NO.: 518 46 6685

17. INFORMANT'S OWN SIGNATURE: Mrs James S. Newton — ADDRESS: Lewiston, Idaho

331X

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): left cerebro-vascular obstruct — 4 months.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* april, 1960, *to* 22 Nov., 1967, *that I last saw the deceased alive on* 22 Nov., 1967, *and that death occurred at* 2:55 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE: B R Stein 496 (Degree or title) MD 1

23b. ADDRESS: Lewiston Idaho

23c. DATE SIGNED: 28 Nov 67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1

24b. DATE: 24 Nov 1967

24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gard.

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-4-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: L. E. DeBaun — Malcom's Brower-Wann Memo. Chapel

LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar, and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5117
Local Reg. No. 275
Reg. Dist. No. 220

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) -1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1121-14th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) Hiram
b. (Middle) D
c. (Last) Eldredge

4. DATE OF DEATH (Month) (Day) (Year) Nov. 22, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Jan. 13, 1889
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) office manager 26
10b. KIND OF BUSINESS OR INDUSTRY dray line
11. BIRTHPLACE (State or foreign country) Devils Lake, N.D.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME C.T. Eldredge — BIRTHPLACE Mich.
14. MOTHER'S MAIDEN NAME Katherine Robison — BIRTHPLACE No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-01-1601
17. INFORMANT'S OWN SIGNATURE Howard W. Eldredge — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary artery thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2-3 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Not seen until arrival at hospital, DOA. *to* _____, 19__, *that I ~~last saw~~ the deceased alive on* _____, 19__, *and that death occurred at* 11 30 p *m., from the causes and on the date stated above.*

23a. SIGNATURE B R Stein 496 (Degree or title) MD.
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED 29 Nov. 67.

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Nov. 27, 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 11-27-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER V. Vassar
LICENSE NO. E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Stover

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5118
Local Reg. No. 280
Reg. Dist. No. 220

BIRTH NO.

DEC 11 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY IN this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1611 Powers

3. NAME OF DECEASED (Type or Print): a. (First) Clarence b. (Middle) E. c. (Last) Vantrease

4. DATE OF DEATH: (Month) 11 (Day) 26 (Year) 67

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 29, 1904

9. AGE (In years last birthday): 63 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Lumber Checker 11

10b. KIND OF BUSINESS OR INDUSTRY: PFI

11. BIRTHPLACE (State or foreign country): Palouse, Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas Vantrease — BIRTHPLACE: Hamburg Illinois

14. MOTHER'S MAIDEN NAME: Cora Eller — BIRTHPLACE: Hollowell Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): UNKNOWN (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT'S OWN SIGNATURE: Elma Vantrease — ADDRESS: 1611 Powers Lewiston

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2-7 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertension
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Gastro-Intestinal Hemorrages

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 10, 1953, *to* Nov 26, 1967, *that I last saw the deceased alive on* Nov 26, 1967, *and that death occurred at* 7:45 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ron Stover MD (Degree or title) 507

23b. ADDRESS: 939 Bryden LEWISTON, IDA.

23c. DATE SIGNED: 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Nov. 30, 1967

24c. NAME OF CEMETERY OR CREMATORY: Lewis and Clark Gardens

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 11-30-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: W.C. Merchant — LICENSE NO.: 240-03-472

FIRM NAME: Merchant Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: MAR 15 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5119
Local Reg. No. 278
Reg. Dist. No. 220

BIRTH NO.

RECEIVED DEC 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 350 b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
d. STREET ADDRESS (If rural, give location) 1137 Hemlock

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Margaret	S.	Abel	November 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	divorced 4	April 6, 1926	41				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
waitress 08	resturant	Fairmont, North Dakota	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
no record		no record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
ni	no record	Mrs. Kathryn D. [illegible]	Springfield, Oregon

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

364X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Malabsorption Syndrome. — INTERVAL BETWEEN ONSET AND DEATH: 7+ mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Polyneuritis. — 7+ mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* April, 19 62, *to* Nov., 19 67, *that I last saw the deceased alive on* 27 Nov., 19 67, *and that death occurred at* 9:30 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B R Klein 496	MD	Lewiston Idaho	29 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Nov. 30, 1967	Normal Hill	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-29-67	Lynette Knott	D Vassar	E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 15 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5120
Local Reg. No. 277
Reg. Dist. No. 220

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

DEC 11 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 NezPerce 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (In this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 290
b. COUNTY Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Juliaetta
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Charles
b. (Middle) H.
c. (Last) Hicks

4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1967

5. SEX male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan 20, 1889
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Dry Ridge, Kentucky
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Thomas Hicks — BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Mattie Sidell — BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-16-3263
17. INFORMANT'S OWN SIGNATURE Hospital Records A.F.V. — ADDRESS Lewiston, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

451X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis generalized
DUE TO (c) Aneurysm of Aorta

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 6, 1967, *to* Nov. 27, 1967, *that I last saw the deceased alive on* Nov 27, 1967, *and that death occurred at* 4:36 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Gordon McWhirter MD 562 (Degree or title) 1
23b. ADDRESS Lewiston Idaho
23c. DATE SIGNED 11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3
24b. DATE Nov 29 1967
24c. NAME OF CEMETERY OR CREMATORY Juliaetta Cemetery
24d. LOCATION (City, town, or county) (State) Juliaetta, Idaho.

DATE REC'D BY LOCAL REG. 11-29-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar
LICENSE NO. E 315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls-Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

SEP 5 1989

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 13 1981

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5121
Local Reg. No. 296
Reg. Dist. No. 220

BIRTH NO.

RECEIVED DEC 22 1967

1. PLACE OF DEATH
a. COUNTY 35 NezPerce 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 3days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lapwai
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Thresa b. (Middle) Adams c. (Last) Andrews

4. DATE OF DEATH (Month) Nov (Day) 28 (Year) 1967

5. SEX Female

6. COLOR OR RACE Indian 3

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH ? 1890

9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Montana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Hays — BIRTHPLACE No record

14. MOTHER'S MAIDEN NAME Thresa Perrish — BIRTHPLACE n record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE + Sam Hayn — ADDRESS Lapwai, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 9008 Pneumonia - + Renal abcess -

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Injury to chest + Kidney
DUE TO (c) Senility -

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify) /

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home 01 3

21c. (CITY, TOWN, OR TOWNSHIP) Lapwai (COUNTY) 350 NezPerce (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Oct 13, 1967 m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2

21f. HOW DID INJURY OCCUR? Fell off stairway

22. *I hereby certify that I attended the deceased from* 10/14/67 *to* 11/28/67, 19___, *that I last saw the deceased alive on* 11/28/67 *and that death occurred at* 5:25A m., *from the causes and on the date stated above.*

23a. SIGNATURE 036 (Degree or title)

23b. ADDRESS 626 5th Ave. Lewiston, Ida.

23c. DATE SIGNED 11/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Nov. 30 67

24c. NAME OF CEMETERY OR CREMATORY Sweetwater Cemetery

24d. LOCATION (City, town, or county) (State) Sweetwater, Idaho.

DATE REC'D BY LOCAL REG. 12-18-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER Andrew H Vassar

LICENSE NO. E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5122
Local Reg. No. 284
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

DEC 11 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston Manor Nursing Home 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 351 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1008 - 9th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) HERMAN
b. (Middle) EDWARD
c. (Last) HAGEDORN

4. DATE OF DEATH (Month) (Day) (Year) 28 Nov 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH 16 January 1885
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Stock & Grain
11. BIRTHPLACE (State or foreign country) Rudd, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Eduard Hagedorn — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Augusta Louisa Schaefer — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 564 32 5193-A
17. INFORMANT'S OWN SIGNATURE Mrs. H. E. Hagedorn — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4918

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Respiratory failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchopneumonia
DUE TO (c) Senility - Cerebral ischemia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1961, 19__, *to* 1968, 19__, *that I last saw the deceased alive on* 28 Nov, 1967, *and that death occurred at* 4:15 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Walter W. Seibly M.D. 757 (Degree or title)
23b. ADDRESS 619 Deaf Clarkston Wash
23c. DATE SIGNED 30 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1 Dec 1967
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-4-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER L. E. DeBaun Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 22 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 20 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5123
Local Reg. No. 283
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
STATEMENT OF STAY (In this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 35
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1613 - 20th Ave.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	KATHARINA	MARIE	SPERLI	28 Nov. 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
Female	White	Married 3	21 Nov. 1926	41				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housekeeper 01	Own Home	Birkenau i/ODW, Germany	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Georg Muller	Germany	Elizabeth ? ?	Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518 32 5761	* Joseph A. Sperli	Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF COLON — INTERVAL BETWEEN ONSET AND DEATH: 12 MONTHS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. 4 YEARS POST OP CARCINOMA OF BREAST

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
4 FEB 67	CARCINOMA OF COLON C METASTASIS	YES ☐ NO XX

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1963, 19__, *to* 28 NOV, 1967, *that I last saw the deceased alive on* 26 NOV, 1967, *and that death occurred at* 3:30 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
227 D and W. Howard MD	307 St John's Way	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1 Dec 1967	Normal Hill Cemetery	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-4-67	Lynette Knoot	L. E. DeBaun Malcom's Brower-Wann Memorial Chapel	E295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

SEP 14 1971

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5124
Local Reg. No. 288
Reg. Dist. No. 220

BIRTH NO.

RECEIVED DEC 22 1967

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 302
b. CITY OR TOWN Lewiston
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1717 - 11th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) IRENE
b. (Middle) ELIZABETH
c. (Last) BROWN

4. DATE OF DEATH (Month) (Day) (Year) 29 November 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH 8 February 1899

9. AGE (In years last birthday) 68
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Rochester, New York

12. CITIZEN OF WHAT COUNTRY USA

13. FATHER'S NAME ????? Kennison
BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME no record
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 026 01 0588

17. INFORMANT'S OWN SIGNATURE Ruth I. Tuckett
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage
INTERVAL BETWEEN ONSET AND DEATH 24 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY. (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 28, 1967, *to* Nov 29, 1967, *that I last saw the deceased alive on* Nov 29, 1967, *and that death occurred at* 8:40 PM, *from the causes and on the date stated above.*

23a. SIGNATURE Ron Glover 507 (Degree or title)

23b. ADDRESS LEWISTON, IDAHO

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 5 Dec 1967

24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-6-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER L. E. DeBaun
Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-295

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021 W

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5125
Local Reg. No. 279
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 11 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 NezPerce 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 312-Adams St 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 312- Adams St

3. NAME OF DECEASED (Type or Print)
a. (First) A
b. (Middle) E
c. (Last) Moser

4. DATE OF DEATH (Month) (Day) (Year) Nov.29.1967

5. SEX male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 24-1886
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired 29
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Joplin, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME C. Moser — BIRTHPLACE norecord
14. MOTHER'S MAIDEN NAME Nancy Clubb — BIRTHPLACE No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-01-6508
17. INFORMANT'S OWN SIGNATURE X Myrtle B. Moser — ADDRESS Lewiston, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ac. Congestive heart — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic failure
DUE TO (c) Cardiovascular Dis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Jgr de III 10 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1962 *to* Idaho 69, *that I last saw the deceased alive on* 11/28/1967, *and that death occurred at* 3 a m., *from the causes and on the date stated above.*

23a. SIGNATURE Galen A. Rogers (Degree or title) 446
23b. ADDRESS MD, Clarkston, Wash
23c. DATE SIGNED 11/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 1, 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) Lewiston, Idaho. (State)

DATE REC'D BY LOCAL REG. 11-30-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER Andrew F. Vassar
LICENSE NO. E-315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 23 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 20 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5126
Local Reg. No. 289
Reg. Dist. No. 220

RECEIVED DEC 22 1967

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 34 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston Manor Nursing Home 312

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 611 - 28th Street

3. NAME OF DECEASED (Type or Print)
a. (First) ROSE
b. (Middle) ELLA
c. (Last) McGARVEY

4. DATE OF DEATH (Month) (Day) (Year) 30 Nov 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 21 May 1876
9. AGE (In years last birthday) 91 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Richmond, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Horace E. Wood — BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Margaret Mitchell — BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 60 9216
17. INFORMANT'S OWN SIGNATURE Walter W. McGarvey — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Infirmities of Age
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 1 week

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1964 *to* Nov 30, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 3:30 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE Ron Stover, M.D. 507 (Degree or title)
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 4 Dec 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-6-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER L. E. DeBaun — Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
DEC 22 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5127
Local Reg. No. 290
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce — CS 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 321 Skyline Drive

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CHARLES	NEWTON	NORBERG	30 November 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	21 July 1891	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Stock & Grain	Pomeroy, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles A. Norberg	Minnesota	Lilly Belle Estes	Washington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No Record	519 42 3257	C.W. Norberg	Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis — 4201

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Sudden

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* — , 19 , *to* Nov , 19 67 , *that I last saw the deceased alive on* Nov 30 , 19 67 , *and that death occurred at* 8:45 AM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] Stower MD	Lewiston Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	2 Dec. 1967	Lewis-Clark Memorial Gardens	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-6-67	Lynette Knott	L. E. DeBaun	E-295

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 07 2004

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5128
Local Reg. No. 22
Reg. Dist. No. 530

Certificate of Death

RECEIVED
NOV 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 360 Oneida 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City
c. LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Oneida County Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 360
b. COUNTY: Oneida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Malad City SPOUSE: Hugh W. Jones
d. STREET ADDRESS (If rural, give location): 401 Bannock St.

3. NAME OF DECEASED (Type or Print)
a. (First): MARGARET MAE
b. (Middle): PALMER
c. (Last): JONES

4. DATE OF DEATH (Month) Nov (Day) 2 (Year) 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: April 16, 1877
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY: --
11. BIRTHPLACE (State or foreign country): Malad City, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Joseph Palmer, Agnabylock, Lncl, England
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Maria Gardner, Preston, Linclnshire, Engl.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 518-60-6175
17. INFORMANT'S OWN SIGNATURE: Lynn P. Jones — ADDRESS: Santa Monica, Cali

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease c̄ Myocardial Decompensation. — INTERVAL BETWEEN ONSET AND DEATH: wks

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c): 1) Liver Decompensation — probable Malignant — wks
2) Nephrosclerosis c̄ uremia — mos.

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1952, *to* 2 NOV, 1967, *that I last saw the deceased alive on* Nov 2, 1967, *and that death occurred at* 1:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 314 (Degree or title): Joseph F. Mabe M.D.
23b. ADDRESS: Malad City, Idaho
23c. DATE SIGNED: Nov. 3, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY: Malad City Cemetery
24d. LOCATION (City, town, or county) (State): Malad, Oneida, Idaho

DATE REC'D BY LOCAL REG.: Nov. 3, 1967
REGISTRAR'S SIGNATURE: Ruth G. Swaten
25. EMBALMER: Raiford G. Benson — Raiford G. Benson
LICENSE NO.: E-351

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: BENSON FUNERAL HOME, MALAD, IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5129
Local Reg. No. 23
Reg. Dist. No. 530

BIRTH NO.

RECEIVED STATE OF IDAHO
DEC 11 1967
Bureau of Vital Statistics

Information, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 360 Oneida
b. CITY OR TOWN (If outside corporate limits, write RURAL and give STATE) Malad
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Power 390
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location) 231 Polk St.

3. NAME OF DECEASED (Type or Print)
a. (First) REINHOLD
b. (Middle)
c. (Last) HOFFMAN

4. DATE OF DEATH (Month) Nov. (Day) 24, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Mar. 30, 1889

9. AGE (In years last birthday) 78 — If under 1 year: Months 7, Days 24 — If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (State or foreign country) Kulm, So. Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Daniel Hoffman — BIRTHPLACE Russia

14. MOTHER'S MAIDEN NAME Magdalena Roloff — BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 518-42-9711A

17. INFORMANT'S OWN SIGNATURE Otilia Hoffman — ADDRESS Am. Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8164

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Irreversible Shock — INTERVAL BETWEEN ONSET AND DEATH 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Internal Thoracic Hemorrhage
DUE TO (c) Auto Accident

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) street 04

21c. (CITY, TOWN, OR TOWNSHIP) Malad City 13 (COUNTY) Oneida 360 (STATE) Idaho

21d. TIME OF INJURY (Month) Nov (Day) 24 (Year) 1967 (Hour) 9:a.m. 55

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? two-car collision

22. *I hereby certify that I attended the deceased from* 2 *19____, to ____, 19____, that I last saw the deceased alive on* Nov. 24, 19 67, *and that death occurred at* 11:40a *m., from the causes and on the date stated above.*

23a. SIGNATURE Raiford G. Benson 583 (Degree or title) Coroner

23b. ADDRESS Malad, Idaho

23c. DATE SIGNED Nov. 25, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial

24b. DATE 11-28-67

24c. NAME OF CEMETERY OR CREMATORY Fallsview Cemetery

24d. LOCATION (City, town, or county) American Falls, (State) Idaho

DATE REC'D BY LOCAL REG. Nov. 28, 1967

REGISTRAR'S SIGNATURE Ruth G. Lunsten

25. EMBALMER Raiford G. Benson — LICENSE NO. E-351

FIRM NAME: Davis Mortuary, American Falls, Id

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 12 1967

DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5130
Local Reg. No. 392
Reg. Dist. No.

RECEIVED DEC 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 370 Owyhee 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Homedale
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 140
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Notus
d. STREET ADDRESS (If rural, give location): Box 124

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): E.
c. (Last): Evans

4. DATE OF DEATH (Month) (Day) (Year): Nov. 29, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 26, 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Avon, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Henry Evans — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Nora Chappel — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): War I 3
16. SOCIAL SECURITY NO.: 519-42-2075
17. INFORMANT'S OWN SIGNATURE: Mrs Walter Evans — ADDRESS:

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immed.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I* ~~*attended the deceased from*~~ investigated only, ~~19~~ on ~~to~~ Nov. 29, 1967, ~~*that I last saw the deceased alive on*~~ ____, ~~19~~ ____, *and that death occurred at* 7:P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Andrew Warfield - Coroner 583
23b. ADDRESS: 4 Homedale Idaho
23c. DATE SIGNED: Dec. 2, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: Wilder Cemetery
24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: Dec. 2 1967
REGISTRAR'S SIGNATURE: Andrew Warfield
25. EMBALMER: Leonard C. Flahiff — LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5131
Local Reg. No. 57
Reg. Dist. No. 330

RECEIVED NOV 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
LENGTH OF STAY (in this place) 6 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 318 W Boulevard 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
d. STREET ADDRESS (If rural, give location) 318 W Boulevard

3. NAME OF DECEASED (Type or Print)
a. (First) DEWEY
b. (Middle)
c. (Last) LEWIN

4. DATE OF DEATH (Month) (Day) (Year) November 2, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH June 19, 1899

9. AGE (In years last birthday) 68
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 21

10b. KIND OF BUSINESS OR INDUSTRY Home Painting

11. BIRTHPLACE (State or foreign country) Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William H. Lewin
BIRTHPLACE Iowa

14. MOTHER'S MAIDEN NAME Gertrude Dye
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 508-05-0897

17. INFORMANT'S OWN SIGNATURE Martha Lewin
ADDRESS New Plymouth

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Massive acute hemorrhage into right chest space — INTERVAL BETWEEN ONSET AND DEATH: One hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchogenic carcinoma right lung — 8 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Right lung removed by operation. Drainage of chest cavity. — 8 months

19a. DATE OF OPERATION Sept 1967
19b. MAJOR FINDINGS OF OPERATION Tumor growth upon right lung lobe. Liver and intestines.
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) —
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* June 19 *1967, to* Nov. 2, *1967, that I last saw the deceased alive on* Nov. 2, *1967, and that death occurred at* 2:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Geo. E. Davis, M.D. (Degree or title) 131
23b. ADDRESS New Plymouth, Idaho
23c. DATE SIGNED 11/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Park View Cemetery
24d. LOCATION (City, town, or county) New Plymouth (State) Idaho

DATE REC'D BY LOCAL REG. 11/6/67
REGISTRAR'S SIGNATURE Roberta E. Shaffer
25. EMBALMER Keith M. Jensen
LICENSE NO. E-517

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5132
Local Reg. No. 58
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 14 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitarium 24.3

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fruitland
d. STREET ADDRESS (If rural, give location) Rt 1 Fruitland

3. NAME OF DECEASED (Type or Print)
a. (First) Nannie
b. (Middle) L
c. (Last) Reece

4. DATE OF DEATH (Month) (Day) (Year) Nov 4 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept 30 1881
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 01
10b. KIND OF BUSINESS OR INDUSTRY Owne Home
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Jim Clevenger — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Amanda Reece — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-22-4866
17. INFORMANT'S OWN SIGNATURE Wm Ray Reece — ADDRESS 516 Colo Ave. Fruitland Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7231

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Viral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 3 to 4 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Chronic disabling spinal osteoarthritis — 2 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Chronic pyelonephritis
Chronic arteriosclerotic cardiac or cerebral ischemia — 10 yrs.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 4, 1966, *to* Nov. 4, 1967, *that I last saw the deceased alive on* Nov. 4, 1967, *and that death occurred at* 3:20pm, *from the causes and on the date stated above.*

23a. SIGNATURE Geo E. Davis M.D. 131 (Degree or title) 1
23b. ADDRESS New Plymouth Idaho
23c. DATE SIGNED Nov. 6 '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal Burial
24b. DATE 11/7/67
24c. NAME OF CEMETERY OR CREMATORY Park View
24d. LOCATION (City, town, or county) New Plymouth (State) Idaho

DATE REC'D BY LOCAL REG. 11/6/67
REGISTRAR'S SIGNATURE Roberta E. Shaffer
25. EMBALMER Donald F. Brown — LICENSE NO. E-408
FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 1 0 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5133
Local Reg. No. 59
Reg. Dist. No. 330

BIRTH NO.

RECEIVED NOV 15 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 380 Payette 100
b. CITY OR TOWN Fruitland
c. LENGTH OF STAY (In this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 602 1st Street 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fruitland
d. STREET ADDRESS (If rural, give location) 602 1st Street

3. NAME OF DECEASED (Type or Print)
a. (First) BEN
b. (Middle) WESLEY
c. (Last) GROVER

4. DATE OF DEATH (Month) (Day) (Year) November 6, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH November 18, 1875

9. AGE (In years last birthday) 91
If under 1 year: Months - Days -
If under 24 hrs.: Hours - Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Livestock Dealer 04

10b. KIND OF BUSINESS OR INDUSTRY Livestock

11. BIRTHPLACE (State or foreign country) New Haven, Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Benjamin Grover
BIRTHPLACE Maine

14. MOTHER'S MAIDEN NAME Maranda Small
BIRTHPLACE Maine

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) - -

16. SOCIAL SECURITY NO. 519-40-1527

17. INFORMANT'S OWN SIGNATURE Marion Grover Ryckoff
NAME AND ADDRESS Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 12, 1967, *to* Nov 6, 1967, *that I last saw the deceased alive on* Nov 24, 1967 *and that death occurred at* 4:30A. m., *from the causes and on the date stated above.*

23a. SIGNATURE Lester W. Scott 679 (Degree or title) M.D.
23b. ADDRESS Ontario, Oregon
23c. DATE SIGNED 11/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/8/67
24c. NAME OF CEMETERY OR CREMATORY Riverside
24d. LOCATION (City, town, or county) Payette (State) Idaho

DATE REC'D BY LOCAL REG. 11-8-67
REGISTRAR'S SIGNATURE Roberta E. Schaffer
25. EMBALMER Keith M. Jensen
LICENSE NO. E-517

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Shaffer Memory Chapel

DUTIES:

NOV 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JAN 15 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25. FEB 17 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5134
Local Reg. No. 60
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
LENGTH OF STAY (in this place) 1 wk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitaruim 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380 b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 906 N. 6th

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Cary	Owen	Andrew	Nov 10 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Nov. 3, 1879	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming 04	Farmer	GrandRiver, Iowa	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Martin Luther Andrew	Iowa	Ermilda Akers	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		334-05-7480	Edith F White	906 N. 6th Payette

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

33 1/X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident and hemiplegia (right) — INTERVAL BETWEEN ONSET AND DEATH: 18 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis and hypertension — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-26-67, 19___, *to* 11-10, 1967, *that I last saw the deceased alive on* 11-10-67 19___, *and that death occurred at* 2:40p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
574 M.D.	Payette, Ida	11-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 14 1967	Rosedale	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-14-67	Roberta E. Duffy	Donald F. Brown / Donadd F. Brown	E-408

FIRM NAME: Chapel of the Roses

Federal Security Agency
United States Public Health Service

Form DH-63021

APR 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5135
Local Reg. No. 63
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 162
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 12 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 1019 3 Ave. South

3. NAME OF DECEASED (Type or Print)
a. (First) Rosa
b. (Middle) Ann
c. (Last) Hadden

4. DATE OF DEATH (Month) (Day) (Year) Nov. 16, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Oct. 6, 1882
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 01
10b. KIND OF BUSINESS OR INDUSTRY Own
11. BIRTHPLACE (State or foreign country) Martinsville, Ind.
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Jacob Fleener — BIRTHPLACE Unk.
14. MOTHER'S MAIDEN NAME Margaret Landrum — BIRTHPLACE Ky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE LaVeta M Dawson — ADDRESS Payette

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH minutes

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Hypertensive arteriosclerotic
DUE TO (c) heart disease — years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* blindness

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, *19*___, *to* 11-16-67, *that I last saw the deceased alive on* 9-29-67, *19*___, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 574 (Degree or title) [signature]
23b. ADDRESS Payette Idaho
23c. DATE SIGNED 11-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11-20-1967
24c. NAME OF CEMETERY OR CREMATORY Midvale, Idaho
24d. LOCATION (City, town, or county) (State) Midvale, Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE Roberta E. Shaffer
25. EMBALMER Robert H Bertelsen — LICENSE NO. Ore. 107
FIRM NAME: Bertelson-Lienkaemper

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 27 1974

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5136
Local Reg. No. 62
Reg. Dist. No. 330

Certificate of Death

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. STAY (in this place) years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 216 N 21st St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 216 N 21st St.

3. NAME OF DECEASED (Type or Print)
a. (First) BETTY
b. (Middle) JEAN
c. (Last) WHITING

4. DATE OF DEATH (Month) (Day) (Year) November 16, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 16, 1927
9. AGE (In years last birthday) 40 — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 04
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Portland, Oregon
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George H. Breckenridge — BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Winifred Petersen — BIRTHPLACE Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - -
16. SOCIAL SECURITY NO. 519-24-5968
17. INFORMANT'S OWN SIGNATURE [signature] — ADDRESS Payette, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2001

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH 5 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) - - - - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) - - - - - - - - -
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) - - - - - - - - - - - - - - - -
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) - - - - - - - - -
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? - - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* June, 1954, *to* Nov 16, 1967, *that I last saw the deceased alive on* Nov 15, 1967, *and that death occurred at* 1:00A *m., from the causes and on the date stated above.*

23a. SIGNATURE Thomas W Watts Jr 553 (Degree or title) M.D.
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED 11/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/18/67
24c. NAME OF CEMETERY OR CREMATORY Riverside
24d. LOCATION (City, town, or county) Payette (State) Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE Roberta E Shaffer
25. EMBALMER Keith M. Jensen
LICENSE NO. E-517

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Shaffer Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 30 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5137
Local Reg. No. 67
Reg. Dist. No. 330

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 000
b. CITY OR TOWN Payette
d. FULL NAME OF HOSPITAL OR INSTITUTION Payette Sanatarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Payette 380
c. CITY OR TOWN Payette
d. STREET ADDRESS

3. NAME OF DECEASED (Type or Print): a. (First) Lulu; b. (Middle); c. (Last) Shook

4. DATE OF DEATH (Month) (Day) (Year): Nov. 16, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: March 17, 1875

9. AGE (In years last birthday): 92

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Kennerdell, Penn.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel J. Eakin BIRTHPLACE: Kennerdell, Penn.

14. MOTHER'S MAIDEN NAME: Julia Atwell BIRTHPLACE: Kennerdell, Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ----

16. SOCIAL SECURITY NO.: No

17. INFORMANT'S OWN SIGNATURE: Kenneth Shook ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Cerebrovascular Disease — 1 year.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 31, 1966, *to* Nov. 16, 1967, *that I last saw the deceased alive on* Nov. 15, 1967, *and that death occurred at* 1:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: H. H. Arnold M.D. 082 (Degree or title)

23b. ADDRESS: Payette Idaho

23c. DATE SIGNED: 11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 20, 1967

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE: Roberta E. Shaffer

25. EMBALMER: Rodney W. Dakan LICENSE NO. E 508

FIRM NAME: Peckham-Dakan Chapel Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 216.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5138
Local Reg. No. 64
Reg. Dist. No. 330

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 206
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural New Plymouth
c. LENGTH OF STAY (in this place) 6 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 7 Mi. NE of New Plymouth 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 388
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural New Plymouth
d. STREET ADDRESS (If rural, give location) Route #2-7 Mi. NE of New Plymouth

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WILLIAM	MONTFORD	STEWART	November 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	November 9, 1912	55	- / -	- / -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Farm & Ranching	Crest View, Florida	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Stewart	Unknown	~~Lorena~~ LUNA (Unknown)	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- -	262-44-8944	Mrs Wm Stewart	New Plymouth Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - - - -	- - - - -	- - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
- - - - - - - - m.		- - - - -

22. *I hereby certify that I attended the deceased from* Investigation, *to* Nov. 18, 1967, *that I last saw the deceased alive on* xxxxxxxxxxxxxxxx *and that death occurred at* 8:30A. *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hardy H Jackson 583	Coroner 4	Payette, Idaho	11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/21/67	Park View Cemetery	New Plymouth Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Roberta E. Shaffer	Keith M. Jensen	E-517

FIRM NAME: Shaffer Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

State File No. 5139
Local Reg. No. 65
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette — DEC 1 1967 — 505
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Fruitland
c. LENGTH OF STAY (In this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1st St. 1 Mile E.of Fruitland 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fruitland
d. STREET ADDRESS (If rural, give location) 435 3rd St.

3. NAME OF DECEASED (Type or Print): a. (First) MICHAEL — b. (Middle) LEE — c. (Last) WATKINS

4. DATE OF DEATH: (Month) (Day) (Year) November 23,1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Never Married /	October 15,1954	13	-	-	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Never worked 03
10b. KIND OF BUSINESS OR INDUSTRY: Never worked
11. BIRTHPLACE (State or foreign country): California
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William R. Watkins — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Doris Wilson — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service) - -
16. SOCIAL SECURITY NO.: - -
17. INFORMANT'S OWN SIGNATURE: William R. Watkins — ADDRESS: Fruitland, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Basal Skull Fracture — INTERVAL BETWEEN ONSET AND DEATH: Seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident /
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 380 **(STATE)**: Fruitland(Rural) Payette Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 11/ 23/ 67 3 P.M.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Automobile & Go Cart Accident

22. *I hereby certify that I attended the deceased from* Investigated *to* ~~xxxxxxxxxx~~ *that I last saw the deceased alive on* Nov. 23, 1967, *and that death occurred at* 3:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Hardy H Jenson — 583 (Degree or title) Coroner /
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 11/25/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial /
24b. DATE: 11/27/67
24c. NAME OF CEMETERY OR CREMATORY: Park View Cemetery
24d. LOCATION (City, town, or county) (State): New Plymouth Idaho

DATE REC'D BY LOCAL REG.: 11/26/67
REGISTRAR'S SIGNATURE: Roberta E. Shaffer
25. EMBALMER: Keith M. Jensen — LICENSE NO.: E-517
FIRM NAME: Shaffer-Jensen Memory Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service
Form DH-69021

DUTIES:

DEC 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 1 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5140
Local Reg. No. 66
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 380 Payette 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Payette Valley Sanitarium

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 380
b. COUNTY: Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): 1337 2nd Ave. So.

3. NAME OF DECEASED (Type or Print): a. (First) EITHEL b. (Middle) VESTLE c. (Last) BOYD

4. DATE OF DEATH: (Month) (Day) (Year): November 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Married 3	August 2, 1893	74	-	-	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Hopkins, Missouri	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lee Bird	Indiana	Viola Outen	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	-	519-0395-86	Loral E Boyd	Payette, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Toxis — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of breast — 17 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
-	-	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
-	-	-

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
- m.	-	-

22. *I hereby certify that I attended the deceased from* Jan 16, 1956, *to* Nov 28, 1967, *that I last saw the deceased alive on* Nov. 27, 1967, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. H. Harrell,	M.D.	Payette, Idaho	11/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/30/67	Riverside	Payette Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11/29/67	Roberta E. Shaffer	Keith M. Jensen	E-517

FIRM NAME: Shaffer-Jensen Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 13 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5141
Local Reg. No. 67
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 106
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 6 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 10 S 9th 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 10 S 9th

3. NAME OF DECEASED (Type or Print): a. (First) Arthur b. (Middle) Clarence c. (Last) Morrisson

4. DATE OF DEATH (Month) (Day) (Year) November 30,1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH November 18,1896

9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months — Days — | IF UNDER 24 HRS. Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Repairman 06

10b. KIND OF BUSINESS OR INDUSTRY Refridgeration

11. BIRTHPLACE (State or foreign country) Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James Akin Morrisson — BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Mary Ellen Patterson — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW I 3

16. SOCIAL SECURITY NO. 519-22-6472

17. INFORMANT'S OWN SIGNATURE Phyllis M. McNeff — ADDRESS Nampa, Idaho

18. CAUSE OF DEATH 4281

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-30, 19 67, *to* 11-30, 19 67, *that I last saw the deceased alive on* DOA, 19 , *and that death occurred at* 3:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE 374 Norvel Stone — (Degree or title) M.D. — **23b. ADDRESS** Payette, Idaho — **23c. DATE SIGNED** 12/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** 12/4/67 — **24c. NAME OF CEMETERY OR CREMATORY** Cloverdale Mem. Park — **24d. LOCATION** (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 12/4/67 — **REGISTRAR'S SIGNATURE** Roberta E. Shaffer — **25. EMBALMER** Keith M. Jensen — **LICENSE NO.** E-517

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5142
Local Reg. No. 22
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED NOV 16 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Power 390 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location) 729 Ft. Hall Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
FRED		DEEG	November 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Oct. 26, 1894	73	0	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farm	Denewitz Russia	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Deeg	Russia	Katherine Stickel	Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	WW 1	519-40-9110	Lea S. Deeg	Am. Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 163X Cancer Lung

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-25- 19 61 *to* 11-4- 19 67, *that I last saw the deceased alive on* 11-2-67, 19 , *and that death occurred at* 11:15P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
Jno. DeLoss Vail M.D.	American Falls, Idaho	11-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 8, 1967	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-13-67	Callene Stadfield	H. L. Davis	E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: NOV 17 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5143
Local Reg. No. 23
Reg. Dist. No. 500-602

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

NOV 20 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 390 Power 306

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls

c. LENGTH OF STAY (in this place) 6 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 390

b. COUNTY Power

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)

a. (First) JOHN

b. (Middle)

c. (Last) MAYER

4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Oct. 21, 1876

9. AGE (In years last birthday) 91

IF UNDER 1 YEAR: Months 0 Days 20

IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Farm

11. BIRTHPLACE (State or foreign country) South Russia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Gottlieb Mayer

BIRTHPLACE So. Russia

14. MOTHER'S MAIDEN NAME Justina Littau

BIRTHPLACE So. Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-42-7547A

17. INFORMANT'S OWN SIGNATURE x Emil F. Mayer

ADDRESS Am. Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5410

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bleeding Duodenal Ulcer

INTERVAL BETWEEN ONSET AND DEATH 2 dy

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-23-, 1962, *to* 11-11-, 1967, *that I last saw the deceased alive on* 11-11-, 1967 *and that death occurred at* 7:45P *m., from the causes and on the date stated above.*

23a. SIGNATURE 141 (Degree or title) Dillon NP

23b. ADDRESS American Falls, Idaho

23c. DATE SIGNED 11-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-14-67

24c. NAME OF CEMETERY OR CREMATORY Fallsview Cemetery

24d. LOCATION (City, town, or county) (State) American Falls, Idaho

DATE REC'D BY LOCAL REG. 11-17-67

REGISTRAR'S SIGNATURE Callen Sadfield

25. EMBALMER H. L. Davis

LICENSE NO. E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1967

OCT 9 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized and release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 21 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5144
Local Reg. No. 24
Reg. Dist. No. 600-502

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 390 Power 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place) 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) NELLIE b. (Middle) L. c. (Last) FACKRELL

4. DATE OF DEATH (Month) (Day) (Year) Nov. 14, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Nov. 13, 1884

9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months 0 Days 1 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nursing

10b. KIND OF BUSINESS OR INDUSTRY Domestic

11. BIRTHPLACE (State or foreign country) Orderville, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Josiah M. Hoyt BIRTHPLACE Nephi, Utah

14. MOTHER'S MAIDEN NAME Ellen Allce Spencer BIRTHPLACE S. L. City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-14-1497

17. INFORMANT'S OWN SIGNATURE Mrs. Archie Morris ADDRESS Am. Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia C V A — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b) Arteriosclerosis Heart — 6 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21-62 19 *to* 11-14- 19 67, *that I last saw the deceased alive on* 11-14-67, 19 , *and that death occurred at* 11:05A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS American Falls, Idaho

23c. DATE SIGNED 11-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-17-67

24c. NAME OF CEMETERY OR CREMATORY Fallsview Cemetery

24d. LOCATION (City, town, or county) (State) American Falls, Idaho

DATE REC'D BY LOCAL REG. 11-20-67

REGISTRAR'S SIGNATURE Earlene Hadfield

25. EMBALMER H. L. Davis LICENSE NO. E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5145
Local Reg. No. 70
Reg. Dist. No. 140

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 6 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 402 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 402
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location) 412 3rd Street

3. NAME OF DECEASED (Type or Print)
a. (First) Dennis
b. (Middle) Nels
c. (Last) Huhta

4. DATE OF DEATH (Month) (Day) (Year) Oct. 21 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Sept. 30, 1948
9. AGE (In years last birthday) 19 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner 07
10b. KIND OF BUSINESS OR INDUSTRY Mining
11. BIRTHPLACE (State or foreign country) Deadwood, So. Dakota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Nickolas Huhta — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Esther Berglund — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-54-9749
17. INFORMANT'S OWN SIGNATURE Nicholas T. Huhta — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fracture Cervical Spine — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 402 **(STATE)** Wallace, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) October 21, '67 3:45P
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Auto Accident

22. *I hereby certify that I attended the deceased from* 2, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* 3:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE William N. Dire 672 (Degree or title) M.D.
23b. ADDRESS Wallace, Idaho.
23c. DATE SIGNED 28 Oct '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Oct. 25, 1967
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur D Alene (State) Idaho

DATE REC'D BY LOCAL REG. 11-1-67
REGISTRAR'S SIGNATURE Dale J Cornell
25. EMBALMER Derrell J. Juelfs — LICENSE NO. E-518

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:- FEB 29 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5146
Local Reg. No. 71
Reg. Dist. No. 140

RECEIVED DEC 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 400 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone Co. Hospital 136

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 402 b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) Steve b. (Middle) c. (Last) Sulkoski

4. DATE OF DEATH (Month) (Day) (Year): Nov. 2, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Aug. 29, 1889

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Yugoslavia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 709-12-7445

17. INFORMANT'S OWN SIGNATURE: Hospital Records
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 96 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cerebral Hemorrhage, Old — several years
& Cortical Hemiplegia

DUE TO (c) Arteriosclerosis — several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-2, 1967 *to* 11-2, 1967, *that I last saw the deceased alive on* 11-2, 1967, *and that death occurred at* 8:00 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. M. Peterson, M.D. 414

23b. ADDRESS: Wallace, Idaho

23c. DATE SIGNED: 11-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 7, 1967

24c. NAME OF CEMETERY OR CREMATORY: Nine Mile Cemetery

24d. LOCATION (City, town, or county) (State): Wallace Idaho

DATE REC'D BY LOCAL REG.: 11-9-67

REGISTRAR'S SIGNATURE: Dale Cornell

25. EMBALMER: Derrell J. Juelfs

LICENSE NO.: E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5147
Local Reg. No.
Reg. Dist. No.

RECEIVED NOV 10 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 404
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
LENGTH OF STAY (in this place) few hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home at 115 W. Mill St.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 407
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 115 W. Mill St.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
E.	BERNICE	MAST	Nov. 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Feb. 11, 1918	49				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	North Dakota	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Iver Fretheim	Iowa	Marie Hermanson	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No None	502-03-3948	George E Mast	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Thrombosis	instant
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Coronary artery disease	2 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Pneumonia Myocardial Infarction	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Kellogg Shoshone Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 1, 1967 *to* 3 Nov, 1967, *that I last saw the deceased alive on* 3 Oct, 1967, *and that death occurred at* 5:A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Glen M Schlect 539	MD	Kellogg, Idaho	6 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 7, 1967	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
		Ronald Maisel	E 452

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 17 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 13 2010

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5148
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

RECEIVED NOV 10 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 000
b. CITY OR TOWN Kellogg
(If outside corporate limits, write RURAL and give township)
DURATION OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION West Shoshone Gen. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 401 Shoshone
c. CITY OR TOWN Kellogg
d. STREET ADDRESS (If rural, give location) 225 South Division

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	GEORGE	G.	WESTCOTT	Nov.	3,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Mar. 23, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Fire Chief 08	Fire Department	Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Westcott	Missouri	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-40-7508	W. Gay Westcott	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Atrial fibrillation + failure — INTERVAL BETWEEN ONSET AND DEATH: 3 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary fibrosis — ? years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Generalized arteriosclerosis and Senility — ? 10 years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 13 March, 1950, *to* 3 Nov, 1967, *that I last saw the deceased alive on* 3 November, 1967, *and that death occurred at* 7:49 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert R. Cordwell	MD	Kellogg, Idaho	6 Nov 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	Nov. 7, 1967	Smith & Company	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
		Donald Maisel	E452

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

NOV 10 1967

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED DEC 6 1967 Bureau of Vital Statistics STATE OF IDAHO

State File No. 5149
Local Reg. No. 72
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 402 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400 b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Leonard	Willard	Hegbloom	Nov. 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	Oct. 28, 1910	57				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	Ironwood, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	394-01-4799	Gerald L. Hegbloom	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

163X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Lung — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* April 30 *19* 55, *to* Nov. 4, *1967, that I last saw the deceased alive on* Nov. 4, *1967, and that death occurred at* 10:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Box 200 Wallace, Idaho	11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 9, 1967	Mullan Cemetery	Mullan, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 13, 1967	[signature]	Derrell J. Juelfs	E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5150
Local Reg. No. 73
Reg. Dist. No. 140

RECEIVED DEC 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Shoshone 402 000
b. CITY OR TOWN Wallace
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location) Bingville

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) --- c. (Last) Couch

4. DATE OF DEATH: (Month) Nov. (Day) 5, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 11, 1889

9. AGE (In years last birthday): 78 | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07

10b. KIND OF BUSINESS OR INDUSTRY: Mining

11. BIRTHPLACE (State or foreign country): England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Couch
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-03-1904

17. INFORMANT'S OWN SIGNATURE: Mrs. Alice Couch
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2608 Septicemia — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes mellitus — Years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 30, 19 64 *to* Nov. 5, 1967, *that I last saw the deceased alive on* Nov. 5, 1967, *and that death occurred at* 8:40 a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 182 — 23b. ADDRESS: Box 200 Wallace, Idaho — 23c. DATE SIGNED: 11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mullan Cemetery
24d. LOCATION (City, town, or county) (State): Mullan, Idaho

DATE REC'D BY LOCAL REG.: Nov. 13, 1967
REGISTRAR'S SIGNATURE:
25. EMBALMER: Derrell J. Jueliffs
LICENSE NO.: E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5151
Local Reg. No. 74
Reg. Dist. No. 140

BIRTH NO.

NOV 16 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 402 Shoshone 000
b. CITY OR TOWN Wallace
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn
d. STREET ADDRESS (If rural, give location) 1049½ Garden Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Pearl	Laura	Grote	Nov. 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	August 11, 1885	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Nebraska	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ferdinand Petermeyer		Laura Stoneback	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	511-16-5029-D	Miss Fern Grote	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart disease with infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct. 8, 1954, *to* Nov. 6, 1967, *that I last saw the deceased alive on* Nov. 6, 1967, *and that death occurred at* 7:10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Box 200 Wallace, Idaho	11-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 7, 1967	Forest Cemetery	Coeur D Alene, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 13, 1967	[signature]	Derrell J. Juelfs	E-518

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

NOV 16 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5152
Local Reg. No. 75
Reg. Dist. No. 140

Certificate of Death

RECEIVED
DEC 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 402 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
d. STREET ADDRESS (If rural, give location) Vallard Addition

3. NAME OF DECEASED (Type or Print)
a. (First) Cecil
b. (Middle) Lewis
c. (Last) Shepherd

4. DATE OF DEATH (Month) (Day) (Year) Nov. 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 27, 1893
9. AGE (In years last birthday) 74 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Diamond Driller 07
10b. KIND OF BUSINESS OR INDUSTRY Mining
11. BIRTHPLACE (State or foreign country) England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Shepherd BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-10-3001
17. INFORMANT'S OWN SIGNATURE Mrs. Alice Shepherd ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary heart disease — INTERVAL BETWEEN ONSET AND DEATH Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 8, 1963, *to* Aug. 8, 1967, *that I last saw the deceased alive on* Aug. 8, 1967, *and that death occurred at* 5:14p *m., from the causes and on the date stated above.*

23a. SIGNATURE E. E. Meadings 482 (Degree or title) MD
23b. ADDRESS Box 200 Wallace, Idaho
23c. DATE SIGNED Nov. 8, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2
24b. DATE Nov. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Smith & Co.
24d. LOCATION (City, town, or county) (State) Spokane, Washington

DATE REC'D BY LOCAL REG. Nov. 13, 1967
REGISTRAR'S SIGNATURE Dale L. Cornell
25. EMBALMER Dale L. Cornell
LICENSE NO. E-406

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5153
Local Reg. No.
Reg. Dist. No.

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

NOV 16 1967

1. PLACE OF DEATH
a. COUNTY 401 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give [illegible]) Kellogg
c. LENGTH OF [illegible]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home at 907 So. Div.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 401 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 907 So. Div.

3. NAME OF DECEASED (Type or Print) a. (First) Elwyn b. (Middle) David c. (Last) Williams

4. DATE OF DEATH (Month) (Day) (Year) Nov. 7, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH June 2, 1910
9. AGE (In years last birthday) 57 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner 07
10b. KIND OF BUSINESS OR INDUSTRY Mining
11. BIRTHPLACE (State or foreign country) Chester, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John E. Williams BIRTHPLACE Colorado
14. MOTHER'S MAIDEN NAME Nora Godfrey BIRTHPLACE Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 530-05-9301
17. INFORMANT'S OWN SIGNATURE Naca Miller ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-7, 1967, *to* 11-7, 1967, *that I last saw the deceased alive on* 11-7, 1967, *and that death occurred at* about 1:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE A. M. Peterson, M.D. 414 (Degree or title)
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 11-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg (State) Idaho

DATE REC'D BY LOCAL REG. 11-14-67
REGISTRAR'S SIGNATURE Joe Irvine
25. EMBALMER Donald Maisel
LICENSE NO. E452

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5154
Local Reg. No.
Reg. Dist. No.

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

NOV 16 1967

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 302
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (In this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Smelterville
d. STREET ADDRESS (If rural, give location) Star Route

3. NAME OF DECEASED (Type or Print)
a. (First) Molly
b. (Middle) A.
c. (Last) Timken

4. DATE OF DEATH (Month) (Day) (Year) Nov. 12, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2
8. DATE OF BIRTH May 2, 1883
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Kindsvater — BIRTHPLACE Russia
14. MOTHER'S MAIDEN NAME Eva Baur — BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-03-5860
17. INFORMANT'S OWN SIGNATURE Mrs. Gladys Mix — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple Trauma Areas — Brain-Skull; Chest, lower Abdomen.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Disease
DUE TO (c) Multiple Pulmonary Emboli

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Hiway Near Smelterville 06
21c. (CITY, TOWN, OR TOWNSHIP) Smelterville 13 — **(COUNTY)** Shoshone 400 — **(STATE)** Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 10 1967 10:15 A.m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Hit by a Car

22. *I hereby certify that I attended the deceased from* 11-10 2, 1967, *to* 11-12, 1967, *that I last saw the deceased alive on* 11-10 -, 1967, *and that death occurred at* 12:50 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE R K Parke MD 765 (Degree or title)
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED 10-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 15, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg — (State) Idaho

DATE REC'D BY LOCAL REG. 11-14-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Donald Maisel — LICENSE NO. E452

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 16 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5155
Local Reg. No. 95
Reg. Dist. No. 142

RECEIVED
NOV 21 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 37 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Greenacres
d. STREET ADDRESS (If rural, give location) Greenacres, Washington

3. NAME OF DECEASED (Type or Print)
a. (First) L.
b. (Middle) ALICE
c. (Last) McCORKLE

4. DATE OF DEATH (Month) (Day) (Year) Nov. 13, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Oct. 20, 1888
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Wirrick — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Milinda James — BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 534-44-4423
17. INFORMANT'S OWN SIGNATURE Elmer Clossett — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ca of Colon c Metastases

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) + 2nd anemia

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH: 2 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 5, 1965, *to* Nov 13, 1967, *that I last saw the deceased alive on* Nov 13, 1965, *and that death occurred at* 9 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert Stalin 494 (Degree or title) MD
23b. ADDRESS Kellogg Idaho
23c. DATE SIGNED 11-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY Forest
24d. LOCATION (City, town, or county) Coeur D'Alene, (State) Idaho

DATE REC'D BY LOCAL REG. 11-20-67
REGISTRAR'S SIGNATURE Joe [illegible]
25. EMBALMER Robert G. Ross — LICENSE NO. E-497

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: MAISEL FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to.

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5156
Local Reg. No. 96
Reg. Dist. No. 142

Certificate of Death

RECEIVED
DEC 6 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home at Pinehurst, Idaho 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pinehurst
d. STREET ADDRESS (If rural, give location) Pinehurst, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) Henry
b. (Middle) E.
c. (Last) Siercke

4. DATE OF DEATH (Month) (Day) (Year) Nov. 15, 1967

5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 9, 1898
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Timberman 07
10b. KIND OF BUSINESS OR INDUSTRY Mining
11. BIRTHPLACE (State or foreign country) Shell Lake, Wis.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME August Siercke — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Harriet Saalass — BIRTHPLACE Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-03-7021
17. INFORMANT'S OWN SIGNATURE Mrs Elizabeth K. Siercke — ADDRESS 4281

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-15, 1967, *to* 11-15, 1967, *that I last saw the deceased alive on* 11-15, 1967, *and that death occurred at* about 2:05 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE G. M. Peterson, M.D. 414 (Degree or title)
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 11-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY Shoshone Mem. Grdns
24d. LOCATION (City, town, or county) Pinehurst, (State) Idaho

DATE REC'D BY LOCAL REG. 12-1-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Robert G. Ross
LICENSE NO. E-497

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 6 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5157
Local Reg. No. 77
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone Co. Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 407 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg 605
d. STREET ADDRESS (If rural, give location) W 308 Riverside St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	William	F.	Wellington	Nov. 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Widowed 2	Dec. 9, 1873	93				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Minister 18	Ministry	Moserville, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Wellington		Unknwon	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		556-36-0425	Loyton W. Wellington	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

33 1/4

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis Generalized, Cerebral Severe — Several years

DUE TO (c) Chronic Brain Syndrome — Several years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic fibrocystic changes both lungs — Several years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1-4, 1967, *to* 11-17, 1967, *that I last saw the deceased alive on* 11-17, 1967, *and that death occurred at* 12:37 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
A. M. Peterson	M.D.	Wallace, Idaho	11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 20, 1967	Peone Prairie Cem	Mead, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Nov. 21, 1967	Ward Cornell	Derrell J. Juelfs	E-518

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 11 1985

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 6 1967 Vital Statistics Bureau

State File No. 5158
Local Reg. No. 94
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 402 Shoshone 201
b. CITY OR TOWN Silverton
c. LENGTH OF STAY (in this place) 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) County Nursing Home 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 481 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 29½ Flume Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)
	JOHN		ROMAN

4. DATE OF DEATH (Month) (Day) (Year): Nov. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Divorced 4	Aug. 10, 1904	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Rancher 04	Ranching	Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lee Roman	Unknown	Emily Myers	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	529-16-4482	[signature]	

4231

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardiovascular Disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Kellogg Shoshone Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 5-25, 1967, *to* 11/18/67, 19___, *that I last saw the deceased alive on* 10-10, 1967, *and that death occurred at* 11:45 P.M. *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R K Purdy	MD	Kellogg Idaho	11-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 22, 1967	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-1-67	[signature]	Robert H. Kass	E-497

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5159
Local Reg. No. 76
Reg. Dist. No. 140

RECEIVED DEC 6 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 002 Shoshone
b. CITY OR TOWN Wallace
c. LENGTH OF STAY (If outside this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Provicence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Valerie	DeEtt	Huff	Nov. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Female	White	Never Married	May 31, 1966	1		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
02		Wallace, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Huff	Minnesota	Grace Reynolds	Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		X Thomas Nolan Huff	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial Spasm — Interval between onset and death: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Acute bronchial asthma — day

DUE TO (c) Acute Severe pneumonitis — 3da

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 1967, 19__, *to* Nov 19, 1967, *that I last saw the deceased alive on* Nov 19, 1967, *and that death occurred at* 9:45A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert J Revelli	435 M.D.	Wallace, Idaho	11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 22, 1967	Murray Cemetery	Murray, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-20-67	Dale L Cornell	Dale L. Cornell	E-406

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5160
Local Reg. No. 79
Reg. Dist. No. 140

BIRTH NO. RECF

NOV 15 1967

Bureau of Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 102 Shoshone

b. CITY OR TOWN Wallace

c. LENGTH OF STAY IN (If outside this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION Providence Hospital 139

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 400

b. COUNTY Shoshone

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan

d. STREET ADDRESS (If rural, give location) 3rd Street, Earle Ave.

3. NAME OF DECEASED (Type or Print)

a. (First) Fred

b. (Middle) Samuel

c. (Last) Kinzie

4. DATE OF DEATH (Month) (Day) (Year) Nov. 27, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 16, 1880

9. AGE (In years last birthday) 87 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith 07

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Bern, Switzerland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE Samuel Kinzie

14. MOTHER'S MAIDEN NAME BIRTHPLACE Marion Christen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | (If yes, give war or dates of service) 1898 - 1901

16. SOCIAL SECURITY NO. 518-01-3571

17. INFORMANT'S OWN SIGNATURE X Anna Kinzie ADDRESS

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

592X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic nephritis — INTERVAL BETWEEN ONSET AND DEATH 4 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-3-67, 19___, *to* 11-27-67 19___, *that I last saw the deceased alive on* 11-27-67, 19___, *and that death occurred at* 5:20a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Graedinger MD

23b. ADDRESS Box 200 Wallace, Idaho

23c. DATE SIGNED 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov 1, 1967

24c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery

24d. LOCATION (City, town, or county) Coeur D Alene (State) Idaho

DATE REC'D BY LOCAL REG. 12-12-67

REGISTRAR'S SIGNATURE Dale Cornell

25. EMBALMER Derrell J. Juelfs

LICENSE NO. E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

DEC 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5161
Local Reg. No. 9
Reg. Dist. No. 620

BIRTH NO.

NOV 28 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 410 Teton 000
b. CITY OR TOWN Driggs (If outside corporate limits, write RURAL and give township) LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Teton Valley Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 410 b. COUNTY Teton
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Driggs
d. STREET ADDRESS (If rural, give location) None Given

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
WILLIAM	S.	DUSTIN	November 13, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	27 Sept. 1885	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer 54	Farming	Garden City, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William H. Dustin	Bountiful, Utah	Sarah Marie Swanson	Smithfield, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	———	523-03-2713	X Eddie Dustin	Driggs, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY Ooccur?
m.		

22. *I hereby certify that I attended the deceased from* at times to 11-17-67, *that I last saw the deceased alive on* ____ 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
K Heard MD	219	Driggs, Idaho	11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	17 Nov. 67	Parker Cemetery	Parker, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-24-67	Ella Driggs	Robert A. Bean	E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5162
Local Reg. No. 10
Reg. Dist. No. 620

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 410 Teton — DEC 5 1967 — 302
b. CITY OR TOWN (If outside corporate limits or township) Driggs — LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Teton County Hospital 142

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Fremont 221
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Anthony
d. STREET ADDRESS (If rural, give location) 419 West 6th South

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MURIAN	THEODORE	MAY	Nov., 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Widowed 2	19 Sept 1910	57				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sectionman 10	UPRR Co.	Preston, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Theodore May		Christina Olsen	Mink Creek, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No.	518-14-9568	Janice Allgood	St. Anthony, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 2 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1961, *to* Nov. 19, 1967, *that I last saw the deceased alive on* Nov. 19, 1967, *and that death occurred at* 3:10 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
V. Heed	219	Driggs, Idaho	29 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	22 Nov 67	Wilford Cemetery	St. Anthony, Idaho RFD #1

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-1-67	Ella Griggs	M. L. Hansen	E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

DUTIES:

DEC 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 5 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 13 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5163
Local Reg. No. D-384
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH — NOV 9 1967
a. COUNTY: 42 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
Bureau of Vital Statistics
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 42 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 211 Monroe Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOHN	G.	WALKER	11- 1- 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	6-14-1876	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Des Moines, Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: UNKNOWN — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: UNKNOWN — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-22-7580
17. INFORMANT'S OWN SIGNATURE: x Geo. E Johnson — ADDRESS: Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Myocardial Infarction
DUE TO (c): Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Investigation Only, 19__, to ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 12:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. Thad Scholes 583	Coroner M.D. 4	Twin Falls, Idaho	11-3-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	10-4-1967	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-6-67	Pamela J. Johnson	Robert C Walk	E294

FIRM NAME: Walk Mortuary — Rupert, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 3 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5164
Local Reg. No. D 388
Reg. Dist. No. 460

RECEIVED NOV 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
c. If STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 106 6th Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer 83328
d. STREET ADDRESS (If rural, give location) 106 6th Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	RUBY	C.	BLAKESLEE	November 2nd, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Mar. 3, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Josiah Conner	Kansas	Louisa J. Hunter	unk

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	~~-~~	551-20-0728 A	X Lena E. Brown	Richfield, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Bronchopneumonia	2 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)	Scirrhous carcinoma of stomach with metastases	6 months
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Abscess of incision, uremia	1 week

1517

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-11-58, 19___, *to* 11-2-67, 19___, *that I last saw the deceased alive on* 11-2-67, 19___, *and that death occurred at* 12:35 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Willard A. Chadwick MD	Twin Falls, Idaho	11.2.67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11.4.67	Richfield Cem	Richfield, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-6-67	Pamela J. Johnson	Donald J. Hamilton	#470

Federal Security Agency
United States Public Health Service

Form DH-6021

FIRM NAME: White Mortuary TwinFalls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 10 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5165
Local Reg. No. D-327
Reg. Dist. No. 460

RECEIVED NOV 9 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 427 Twin Falls
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 428
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Buhl 83316
d. STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print) a. (First) JENNIE b. (Middle) H. c. (Last) BARNES

4. DATE OF DEATH (Month) (Day) (Year) Nov. 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	Widowed 2	Mar. 16, 1889	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Homemaking	Lewiston, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George Holliday	Fencote, England	Isabella Wallace	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	-----	519-24-6753A	x Luella Smellie	Buhl, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

332 X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* May 13, 1963, *to* Nov 3, 1967, *that I last saw the deceased alive on* Nov 2, 1967, *and that death occurred at* 1:15A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Dean H Applebee MD 003	231-4th Ave North, Twin Falls Idaho	6 Nov 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Nov. 6, 1967	Hyrum Cemetery	Hyrum, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-6-67	Pamela J. Johnson	Donald J. Hamilton	#470

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 8 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5166
Local Reg. No. D-391
Reg. Dist. No. 460

RECEIVED
NOV 16 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 12 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 143 Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 160
b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Declo
d. STREET ADDRESS (If rural, give location) Route #1 NE of Declo

3. NAME OF DECEASED (Type or Print)
a. (First) Olevia
b. (Middle) Lewann
c. (Last) Banner

4. DATE OF DEATH (Month) (Day) (Year) Nov. 7, 1967

5. SEX female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct.20,1908
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR Months 0 Days 18 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Liberty, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Albert Hymas, BIRTHPLACE Liberty, Idaho
14. MOTHER'S MAIDEN NAME Emma Josephine Johnson, BIRTHPLACE Ovid, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - -
16. SOCIAL SECURITY NO. 518-54-3039
17. INFORMANT'S OWN SIGNATURE C. LeRoy Banner ADDRESS Declo, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 163X Adeno Carcinomatosis of both lungs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) and pericardium
DUE TO (c) Source unknown

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION Oct 13 1967
19b. MAJOR FINDINGS OF OPERATION Adeno-Metastatic Carcinoma both lungs and pericardium
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug. 14, 1967, *to* Nov. 7, 1967, *that I last saw the deceased alive on* Nov. 7, 1967, *and that death occurred at* 10:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE B.L. Kreilhang M.D. 296 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 11-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Nov.10,1967
24c. NAME OF CEMETERY OR CREMATORY Declo Cemetery
24d. LOCATION (City, town, or county) Declo, (State) Idaho

DATE REC'D BY LOCAL REG. 11-14-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER Ormand F. Burch
LICENSE NO. E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCulloch Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 2 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5167
Local Reg. No. D-393
Reg. Dist. No. 460

BIRTH NO. 67-11251 RECEIVED NOV 16 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give place): Twin Falls
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 428
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
d. STREET ADDRESS (If rural, give location): Kimberly

3. NAME OF DECEASED (Type or Print): a. (First) MICHAEL b. (Middle) L c. (Last) CANNON

4. DATE OF DEATH: (Month) 11 (Day) 9 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: 11 - 7 - 1967

9. AGE (In years last birthday): 0 | IF UNDER 1 YEAR: Months 0, Days 2 | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Twin Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Michael L. Cannon — BIRTHPLACE: Kansas City, Mo.

14. MOTHER'S MAIDEN NAME: Rose Craig — BIRTHPLACE: Twin Falls, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mike L Cannon — General ADDRESS: Dilivery Kimberly

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7620 Infantile Neonatal respiratory distress syndrome — INTERVAL BETWEEN ONSET AND DEATH: 2 d

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Neonatal atelectasis — 2 d
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [XX] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11-7, 1967, *to* 11-9, 1967, *that I last saw the deceased alive on* 11-9, 1967, *and that death occurred at* 8:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Werner H Kramer 293 (Degree or title) M.D.

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 11-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-13-67

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 11-15-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Paul D. Reynolds

LICENSE NO.: E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5168
Local Reg. No. D-399
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 401 Twin Falls 151
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place) 51 YEARS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 46
b. COUNTY 401 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 206 Tyler

3. NAME OF DECEASED (Type or Print) a. (First) ALFRED b. (Middle) DeWITT c. (Last) STEVENS

4. DATE OF DEATH (Month) (Day) (Year) November 8, 1967

5. SEX Male
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH October 22, 1895
9. AGE (In years last birthday) 72 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Telephone Man 09
10b. KIND OF BUSINESS OR INDUSTRY Communications
11. BIRTHPLACE (State or foreign country) Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Albert M. Stevens
BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Julia Ann Yoder
BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) — —
16. SOCIAL SECURITY NO. 518-07-2212
17. INFORMANT'S OWN SIGNATURE X Edna P. Stevens ADDRESS Twin Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 8 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 5, 1967, *to* Nov 8, 1967, *that I last saw the deceased alive on* Nov 8, 1967, *and that death occurred at* 6:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE [illegible] MD (Degree or title)
23b. ADDRESS [illegible]
23c. DATE SIGNED 11-9-1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 11-16-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Gerald J. Hamilton
LICENSE NO. E-470

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1967

NOV 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5169
Local Reg. No. 0-392
Reg. Dist. No. 460

RECEIVED NOV 16 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 420 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 306 Monroe Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kimberly
d. STREET ADDRESS (If rural, give location): 306 Monroe Street

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) JAMES c. (Last) FITZHUGH

4. DATE OF DEATH (Month) (Day) (Year): November 9, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: November 11, 1887

9. AGE (In years last birthday): 79 | IF UNDER 1 YEAR Months: | Days: | IF UNDER 24 HRS. Hours: | Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stockman-Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Weaubleau, Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Thomas Fitzhugh — BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Sarah E. Monroe — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 544-12-0381

17. INFORMANT'S OWN SIGNATURE: Claude W. Fitzhugh, ADDRESS: Kimberly, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 24 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart Disease 10 years

DUE TO (c) Arteriosclerosis generalized 10 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 11-8, 1967, *to* 11/9/, 1967, *that I last saw the deceased alive on* 11/8, 1967, *and that death occurred at* 10:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: O. Ellis Knight 286 (Degree or title) M.D. 1

23b. ADDRESS: Kimberly, Idaho

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/13/67

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 11-15-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Paul D. Reynolds — LICENSE NO.: E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-6302

DUTIES:

NOV 1 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 6 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5170
Local Reg. No. 12-39
Reg. Dist. No. 460

BIRTH NO. 67-10296

RECEIVED NOV 20 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 42 Twin Falls 000

b. CITY OR TOWN Twin Falls

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 743

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 270

b. COUNTY Jerome

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hazelton 83335

d. STREET ADDRESS (If rural, give location) Box 154

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ERIC	KENDALL	SYVERSON	November 10, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Single	October 5, 1967		1	7		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
NONE 02	— —	Twin Falls, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Kendall Syverson	Idaho	Shirley Etherington	Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	— —	NONE	X Kendall Syverson	Hazelton

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 7562 Atelectasis — bilateral — INTERVAL BETWEEN ONSET AND DEATH 36 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Tracheoesophageal fistula — 1 Mo. 7 dy

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hydronephrosis r Kidney — 1 Mo. 7 dy

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/5, 1967, *to* 11/10, 1967, *that I last saw the deceased alive on* 11/9, 1967, *and that death occurred at* 9:00 AM., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ben [illegible] 274	MD	Twin Falls	11/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/13/67	Twin Falls, Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-16-67	Pamela J. Johnson	Ronald J. Hamilton	E-470

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service

Form DH-65021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5171
Local Reg. No. 10-396
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 138
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 36 YEARS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 743

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer 83328
d. STREET ADDRESS (If rural, give location) 516 Midway

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) G. c. (Last) MOHLENBRINK
4. DATE OF DEATH (Month) (Day) (Year) Nov. 11, 1967
5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH July 9, 1881
9. AGE (In years last birthday) 86 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY farming
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Henry Mohlenbrink BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Louise Minike BIRTHPLACE Kansas
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ----
16. SOCIAL SECURITY NO. 519-01-1275A
17. INFORMANT'S OWN SIGNATURE Mrs Rhama Mohlenbrink ADDRESS Filer, Idaho

9317

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Generalized arteriosclerosis — years

DUE TO (c) Cerebral arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 6, 1967, *to* Nov 11, 1967, *that I last saw the deceased alive on* July 11, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD
23b. ADDRESS 1122 9th Ave No Buhl
23c. DATE SIGNED 11-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Filer IOOF Cemetery
24d. LOCATION (City, town, or county) Filer, Idaho (State)

DATE REC'D BY LOCAL REG. 11-16-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Ronald J. Hamilton
LICENSE NO. E-470
FIRM NAME: White Mortuary

Federal Security Agency
United States Public Health Service
Form DH-630 21

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5172
Local Reg. No. D-398
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 20 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 50 YEARS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) Rural Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First) MINNIE
b. (Middle) O.
c. (Last) MacKAY

4. DATE OF DEATH (Month) (Day) (Year) November 12, 1967

5. SEX Female
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 31, 1896
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY --
11. BIRTHPLACE (State or foreign country) Mt. Grove, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John C. Walker — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Rosa Lee Melton — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 518-34-3336A
17. INFORMANT'S OWN SIGNATURE X Neil MacKay — ADDRESS Jerome, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Colon — INTERVAL BETWEEN ONSET AND DEATH 6 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 28, 1949, *to* Nov 12, 1967, *that I last saw the deceased alive on* Nov 12, 1967, *and that death occurred at* 12:25 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE Jean H Affleck MD 003 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 14 Nov. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 11/15/67
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. 11-16-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Ronald J. Hamilton
LICENSE NO. E-470

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5173
Local Reg. No. 2400
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 42 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 1542 Addison Avenue East

3. NAME OF DECEASED (Type or Print) a. (First) ANNA b. (Middle) c. (Last) SCHNELL

4. DATE OF DEATH (Month) (Day) (Year) November 13, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Nov. 1, 1890
9. AGE (In years last birthday) 77 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Yugoslavia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wendall Leonard BIRTHPLACE Yugoslavia
14. MOTHER'S MAIDEN NAME Anna Lang BIRTHPLACE Yugoslavia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 519-44-7535
17. INFORMANT'S OWN SIGNATURE X Margaret Wood ADDRESS Twin Falls

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 24 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 17 years
DUE TO (c) Benign Hypertension — 17 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Rheumatic Valvulitis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24-57, *to* 11-13, 1967, *that I last saw the deceased alive on* 11-13, 1967, *and that death occurred at* 8:35 A m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title)
23b. ADDRESS 204 4th Ave. East Twin Falls, Idaho 83301
23c. DATE SIGNED 11-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Nov. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. 11-16-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Ronald L. Hamilton
LICENSE NO. E-470

FIRM NAME WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 18 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5174
Local Reg. No. D-395
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED NOV 20 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 111
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 11 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 555 Gardner z/c 83301

3. NAME OF DECEASED (Type or Print)
a. (First) ANDREW
b. (Middle) DORRIS
c. (Last) KERR

4. DATE OF DEATH (Month) (Day) (Year) November 13, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH June 2, 1904
9. AGE (In years last birthday) 63 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sugar factory worker
10b. KIND OF BUSINESS OR INDUSTRY 16 sugar production
11. BIRTHPLACE (State or foreign country) Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Andrew J. Kerr — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Elva M. Smith — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) -0-
16. SOCIAL SECURITY NO. 566-09-8150
17. INFORMANT'S OWN SIGNATURE X Mrs. Clara Kerr — ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Rt — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) lung — 1 year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 17, 1955, *to* Nov 13, 1967, *that I last saw the deceased alive on* Nov 12, 1967, *and that death occurred at* 12:35A *m., from the causes and on the date stated above.*

23a. SIGNATURE Dean H Abbleck M.D. 003 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 14 Nov 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Nov. 17, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) Twin Falls, (State) Idaho

DATE REC'D BY LOCAL REG. 11-16-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Ronald J. Hamilton — LICENSE NO. 470

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

NOV 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended

Certificate of Death

STATE OF IDAHO

State File No. 5175
Local Reg. No. 0-401
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
DEC 26 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 42/ Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 05 California
b. COUNTY: 555 San Bernardino
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): San Bernardino
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) WALLACE b. (Middle) H. c. (Last) CHATTERTON

4. DATE OF DEATH (Month) (Day) (Year): November 16, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 30, 1928

9. AGE (In years last birthday): 39 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Elec. Lineman 21

10b. KIND OF BUSINESS OR INDUSTRY: Jelco, Inc.

11. BIRTHPLACE (State or foreign country): Buhl, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry Chatterton — BIRTHPLACE: Robin, Idaho

14. MOTHER'S MAIDEN NAME: Mae Green — BIRTHPLACE: Norma, South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): U.S. Marines

16. SOCIAL SECURITY NO.: 519-07-8134

17. INFORMANT'S OWN SIGNATURE: Paula Reynolds — ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Diverticulitis c abcess - Sigmoid — INTERVAL BETWEEN ONSET AND DEATH: 1 wk -

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Peritonitis, 2nd to # a — 1 wk
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Biliary cirrhosis — unknown

5224

19a. DATE OF OPERATION: 11-9-67

19b. MAJOR FINDINGS OF OPERATION: Diverticulitis with abcess -

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-9, 1967, *to* 11/16/, 1967, *that I last saw the deceased alive on* 11-14, 1967, *and that death occurred at* 2:20p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Leon W. Warner 551 (Degree or title) M.D. /

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/18/67

24c. NAME OF CEMETERY OR CREMATORY: Buhl Cemetery

24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 12-22-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER James C. Reynolds: James C. Reynolds — **LICENSE NO.**: E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form OH-65021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

State File No. 5175
Local Reg. No. D-201
Reg. Dist. No. 460

BIRTH NO.

RECEIVED NOV 27 1967 Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 224 Carney Street

3. NAME OF DECEASED (Type or Print): a. (First) WALLACE b. (Middle) H. c. (Last) CHATTERTON

4. DATE OF DEATH (Month) (Day) (Year): November 16, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: May 30, 1967

9. AGE (In years last birthday): 39
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Electrical Lineman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Buhl, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Harry Chatterton
BIRTHPLACE: Robin, Idaho

14. MOTHER'S MAIDEN NAME: Mae Green
BIRTHPLACE: Norma, North Dak.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): U.S. Marines

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: x Jon Chatterton
ADDRESS: 116 Boyd Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5721

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peritonitis, fulminating — INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diverticulitis with abscess Sigmoid colon — 1 wk.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Biliary cirrhosis — unknown

19a. DATE OF OPERATION: Nov 9-1967

19b. MAJOR FINDINGS OF OPERATION: Diverticulitis & abscess of sigmoid

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov 9, 1967, *to* 11/16/, 1967, *that I last saw the deceased alive on* 11-16, 1967, *and that death occurred at* 2:20 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leonard Warner M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11/18/67
24c. NAME OF CEMETERY OR CREMATORY: Buhl Cemetery
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 11-20-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: James C. Reynolds James C. Reynolds
LICENSE NO.: E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

NOV 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 5 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 23 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

MAR 21 1968

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

DEC 13 1968

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5176
*Local Reg. No. D-411
Reg. Dist. No. 460

BIRTH NO.

NOV 30 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: 420 Twin Falls 205

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl

c. LENGTH OF STAY (in this place): 5 Months

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: 420 Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl

d. STREET ADDRESS (If rural, give location): 510 South Broadway

3. NAME OF DECEASED (Type or Print): a. (First) EFFIE b. (Middle) J. c. (Last) STARKEY

4. DATE OF DEATH: (Month) Nov. (Day) 16, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Jan. 13, 1889

9. AGE (In years last birthday): 78 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Altoona, Kansas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James McGrannahan — BIRTHPLACE: North Carolina

14. MOTHER'S MAIDEN NAME: Frances Williams — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-26-8467 A

17. INFORMANT'S OWN SIGNATURE: Louise Williams — ADDRESS: RFD # 1 Buhl, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion	Minutes
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	arteriosclerotic heart dis	Years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 21, 1961, *to* November 1967, *that I last saw the deceased alive on* October 31, 1967, *and that death occurred at* 6:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] MD (Degree or title)

23b. ADDRESS: 1122 9th Ave No. Buhl

23c. DATE SIGNED: 11-17-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/21/67

24c. NAME OF CEMETERY OR CREMATORY: Buhl

24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 11/29/67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Robert F. Dickard — **LICENSE NO.**: E-312

FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 9 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Amended December 8, 1967

Certificate of Death

STATE OF IDAHO

State File No. 5177
Local Reg. No. D-406
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls 421 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls 421
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 1037 Elm St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Clarence	H. 743	Motzner	November 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Caucasian	Married 3	Sept 30, 1912	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Station Operator 06	Petroleum	Russell Co., Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Frederick Motzner	West Prussia	Kathyrn Strecker	South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	512-03-4894	Mrs. Clarence Motzner	Twin Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cardio genic shock	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Acute Myocardial Infarction	3 days
DUE TO (c)	Coronary Artery Disease	1 year
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO XX

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 19 58, *to* Nov 17, 19 67, *that I last saw the deceased alive on* Nov 17, 19 67, *and that death occurred at* 10:28P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Max W. Carver, M.D.	085	Twin Falls, Idaho	Nov 21, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 21, 1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-27-67	Pamela J. Johnson	Edgar Robertson	E-507

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: White Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

State of Idaho } ss.
County of Twin Falls

RECEIVED
DEC 8 1967
Bureau of Vital Statistics

Certificate No.

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)

for Clarence H. Motzner (Name on Original Certificate) who died (Was Born or Died) on Nov 17, 1967 (Date of Event)

in Twin Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
#8 Date of Birth	Sept 30, 1967	Sept 30, 1912

Subscribed and sworn to before me this day of , 19

Notary Public, residing at

My commission expires

(Seal)

Signed White Mortuary Negr.
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Box 845 Twin Falls, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Ida } ss.
County of Twin Falls

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 7 day of December, 1967

Notary Public, residing at Twin Falls Ida

My commission expires April 13 - 1970

(Seal)

Signed Russell D. Nikol
(Signature of Any Credible Person)

410 Martin, Twin Falls, Idaho
(Street Address, City, State)

White Mortuary, Associate

FORM DH 60-155

12-5-67

Certificate of Death

State File No. 12-406
Local Reg. No.
Reg. Dist. No. 460

RECEIVED
NOV 30 1967
Bureau of Vital Statistics
STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (If this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 1037 Elm St.

3. NAME OF DECEASED (Type or Print): a. (First) CLARENCE b. (Middle) H. c. (Last) MOTZNER

4. DATE OF DEATH (Month) (Day) (Year): November 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	Caucasian	Married	Sept. 30, 1967	55				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Station Operator	Petroleum	Russell Co., Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Frederick Motzner	West Prussia	Kathyrn Strecker	South Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	512-03-4894	Mrs. Clarence Motzner	Twin Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cardiogenic shock. — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Myocardial infarction — 3 days.
DUE TO (c) Coronary Artery Disease — 1 year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July, 1958, *to* Nov 17, 1967, *that I last saw the deceased alive on* Nov 17, 1967, *and that death occurred at* 10:25 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Max W. Garst M.D.	Twin Falls, Idaho	Nov 21, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 21, 1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-27-67	Pamela J. Johnson	Edgar Robertson	E-507

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 8 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 12 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5178
Local Reg. No. D-487
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls, 153
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 53 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 463

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hansen
d. STREET ADDRESS (If rural, give location) Route 1, 83334

3. NAME OF DECEASED (Type or Print)
a. (First) CHARLES NEWTON
b. (Middle) NEWTON
c. (Last) DOPSON

4. DATE OF DEATH (Month) (Day) (Year) November 18, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Sept. 26, 1891
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming 04
10b. KIND OF BUSINESS OR INDUSTRY agriculture
11. BIRTHPLACE (State or foreign country) Monett, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry Newton Dopson — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Eliza Brixey — BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no
16. SOCIAL SECURITY NO. 518-42-2197A
17. INFORMANT'S OWN SIGNATURE X Naomi Dopson — ADDRESS Twin Falls, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 11 months

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic Heart disease and Nephrosclerosis — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes Mellitus — 4 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1963, *to* Nov 18, 1967, *that I last saw the deceased alive on* Nov 17, 1967, *and that death occurred at* 6:00 Am., *from the causes and on the date stated above.*

23a. SIGNATURE Max W. Bower 085 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED Nov 21, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Nov. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. 11/27/67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Edgar Robertson — LICENSE NO. E-507

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to report the facts shall sign HIS name in addition to giving the source of information.

DEC 1 1967

DEC 18 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5179
Local Reg. No. D-412
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 114
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 14 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Hazeldel Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rt. #1 Twin Falls
d. STREET ADDRESS (If rural, give location) Rt. #1

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPHINE
b. (Middle) MADSEN
c. (Last) BECK

4. DATE OF DEATH (Month) (Day) (Year) Nov. 19, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Feb. 19, 1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Chester, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew Madsen-Uzderrup, BIRTHPLACE Denmark
14. MOTHER'S MAIDEN NAME Annie Maria Jensen, BIRTHPLACE Salt Lake City, Uta

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE x Mrs Myrtle Goold, ADDRESS Twin Falls, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

442X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Cardiac & Renal failure c. anemia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive Cardiovascular Renal disease
DUE TO (c) Old age Gen Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1966, *to* April, 1967, *that I last saw the deceased alive on* Nov 19, 1967, *and that death occurred at* PM *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 1461 (Degree or title) MD
23b. ADDRESS 594 Hazeldel Dine
23c. DATE SIGNED 11 21 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Nov. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery
24d. LOCATION (City, town, or county) Paul (State) Idaho

DATE REC'D BY LOCAL REG. 11/28/67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. E-389

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 13 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 9 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5180
Local Reg. No. D-402
Reg. Dist. No. 460

RECEIVED
NOV 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 424
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
LENGTH OF STAY in this place: 24 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 428 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hansen
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) EARL b. (Middle) AUSTIN c. (Last) MC GEE

4. DATE OF DEATH (Month) (Day) (Year): Nov. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed 2	Feb. 5, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	General labor	Montana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Austin McGee	Utah	Phoebe Brower	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	- - - - - -	519-01-0704	Welfare records	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9702

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Over Dosage Sleeping Pills — Self administered — 24 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) (STATE)
Suicide 2	00	

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
- - - - - - - m.		

22. *I hereby certify that I attended the deceased from* June 19 67 *to* Nov 19 1967, *that I last saw the deceased alive on* Nov 19, 1967 *and that death occurred at* 9:45 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Willard M. Peterson MD	Twin Falls, Idaho	11-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	11-22-67	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-22-67	Pamela J Johnson	Dan P. Patterson	E-451

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: TWIN FALLS MORTUARY

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5181
Local Reg. No. D-405
Reg. Dist. No. 460

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
DURATION OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly 83341
d. STREET ADDRESS (If rural, give location) 603 Jefferson St.

3. NAME OF DECEASED (Type or Print)
a. (First) Earl
b. (Middle) B.
c. (Last) Sallee

4. DATE OF DEATH (Month) (Day) (Year) November 19, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Sept. 4, 1901

9. AGE (In years last birthday) 66
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Nevada, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles Sallee
BIRTHPLACE Unk.

14. MOTHER'S MAIDEN NAME Annie Becraft
BIRTHPLACE Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-42-5563

17. INFORMANT'S OWN SIGNATURE Mrs Lisle Sallee ADDRESS Kimberly, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral hemorrhage (right) — INTERVAL BETWEEN ONSET AND DEATH: 4 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic hypertension — 10 Yrs.
DUE TO (c) Atheromatosis — 5 Yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Coronary heart disease

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Pneumonia (Aspiration)
Abdominal aneurism

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1963, *to* Nov. 19, 1967, *that I last saw the deceased alive on* Nov. 19, 1967, *and that death occurred at* 5:50a m., *from the causes and on the date stated above.*

23a. SIGNATURE Glenn A. Hoss, MD 246 (Degree or title)

23b. ADDRESS 1221 Lynwood Mall, Twin Falls, Idaho 83301

23c. DATE SIGNED Nov. 20, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 22, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 11-27-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Edgar Robertson LICENSE NO. E-507

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 30 1967 Bureau of Vital Statistics

State File No. 5182
Local Reg. No. D-403
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42/ Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley Nursing Home 250

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 42/
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 1795 4th Ave. East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	John	William	Taylor	November 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Jan. 31, 1879	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney 16
10b. KIND OF BUSINESS OR INDUSTRY Law
11. BIRTHPLACE (State or foreign country) Minersville, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Taylor — BIRTHPLACE Wales, England
14. MOTHER'S MAIDEN NAME Mary — BIRTHPLACE USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Ruth T. Retweiler ADDRESS Twin Falls, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 5+ years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — 5+ years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

332 X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-25-, 19 63 *to* 11-19-, 19 67, *that I last saw the deceased alive on* 11-16-, 1967, *and that death occurred at* 1:45p m., *from the causes and on the date stated above.*

23a. SIGNATURE George S. Brown MD (Degree or title) — 23b. ADDRESS Twin Falls, Idaho — 23c. DATE SIGNED 11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 21, 1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 11-27-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Jerry D. Holman — LICENSE NO. E-[redacted]516
FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 28 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5183
Local Reg. No. D-413
Reg. Dist. No. 460

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY: 421 Twin Falls 310

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

c. LENGTH OF STAY (In this place): 10 Days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 420

b. COUNTY: Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Castleford

d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ETHEL		PETTIJOHN	Nov. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White m	Married 3	March 23, 1892	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Green Creek, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Clausen	Denmark		Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE ADDRESS
No		10800 Georgetown William C. Pettijohn Pike, Great Falls, Va.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) with left hemiplegia

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

332X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 11-9, 1967, *to* Nov 20, 1967, *that I last saw the deceased alive on* 11-20, 1967, *and that death occurred at* 6:30 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wm H Anderson MD	Buhl Idaho	11-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/22/67	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-28-67	Pamela J. Johnson	George Farmer	E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 9 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5184
Local Reg. No. D 404
Reg. Dist. No. 460

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Twin Falls 421 000
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN Twin Falls 83301
d. STREET ADDRESS (If rural, give location) Route# 1

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	SENA	E.	UDE	November 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	May 19, 1967	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Reynolds, Nebraska
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Mane Harms — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Sena Kuhlman — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: 519-24-25148
17. INFORMANT'S OWN SIGNATURE: x August W. Hale — ADDRESS: TwinFalls, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2040

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Bronchopneumonia	Days.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Chronic Lymphocytic Leukemia	10 years.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Arteriosclerotic Heart Disease	5 years.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* mm Feb 24, 19 56, *to* Nov 21, 19 67, *that I last saw the deceased alive on* Nov 21, 19 67 *and that death occurred at* 5:45A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B. L. Kuhlamp MD 296	Twin Falls, Idaho	11 22 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11.25.67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-27-67	Pamela J. Johnson	Ronald J. Hamilton	E-470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5185
Local Reg. No. D-209
Reg. Dist. No. 460

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Valley Nursing Home 250

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 421 b. COUNTY: T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
d. STREET ADDRESS (If rural, give location): 1336 4th Ave. East

3. NAME OF DECEASED (Type or Print)
a. (First): CLYDE b. (Middle): ERLE c. (Last): TOLER

4. DATE OF DEATH (Month) (Day) (Year): November 22, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: December 3, 1889

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Accountant 19

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Arapahoe, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jeter J. Toler
BIRTHPLACE: Charleston, West Va.

14. MOTHER'S MAIDEN NAME: Laura Horton
BIRTHPLACE: Bellevue, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519-07-8134

17. INFORMANT'S OWN SIGNATURE: Gaylord Ed. Toler ADDRESS: Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c): Diabetes Mellitus Congestive Heart Failure, Pulmonary Emphysema, Carcinoma of Prostate

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June, 19 67 *to* 11/22/, 19 67, *that I last saw the deceased alive on* 11/20, 19 67, *and that death occurred at* 12:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Ray L. SHAW 466 (Degree or title): M.D.

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 11/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/24/67

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 11-27-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: James C. Reynolds James C. Reynolds

LICENSE NO.: E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-65021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Item inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 19[illegible]

MAR 13 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5186
Local Reg. No. D-415
Reg. Dist. No. 460

Certificate of Death

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hansen 83334
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) HARRY
b. (Middle)
c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year) November 23, 1967

5. SEX Male
6. COLOR OR RACE Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH June 7, 1908
9. AGE (In years last birthday) 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME L. C. Smith — BIRTHPLACE UNK
14. MOTHER'S MAIDEN NAME Rosa Roberts — BIRTHPLACE Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 521-20-5915
17. INFORMANT'S OWN SIGNATURE Mrs. Harry Smith by Ronald Hamilton — ADDRESS Hansen

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-30-65, 19___, *to* 2-23, 1966, *that I last saw the deceased alive on* ~~11-30~~ 2-23 1966, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE V. V. Telford. MD. 525 (Degree or title)
23b. ADDRESS 153 Blue Lakes Blvd T.F
23c. DATE SIGNED 11-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) Twin Falls (State) Idaho

DATE REC'D BY LOCAL REG. 11-29-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Ronald J. Hamilton
LICENSE NO. E-490

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 12 1968

DEC 7 1987

JUN 24 1991

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended March 1, 1968

Certificate of Death

STATE OF IDAHO

State File No. 5187
Local Reg. No. D-419
Reg. Dist. No. 460

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): R.F.D. #4

3. NAME OF DECEASED (Type or Print): a. (First) Donald; b. (Middle) Edwin; c. (Last) McNelly

4. DATE OF DEATH (Month) (Day) (Year): November 24, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Jan 19, 1922

9. AGE (In years last birthday): 45
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Buhl, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles E. McNelly
BIRTHPLACE: Minnesota

14. MOTHER'S MAIDEN NAME: Iva Hart
BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 519-18-7922

17. INFORMANT'S OWN SIGNATURE: Mayme McNelly Ruffing
ADDRESS: 336 5th Ave. E., Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Artery Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Saw only after arrival at hospital DOA, *19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): V. V. Telford, M.D.

23b. ADDRESS: 153 Blue Lakes N., Twin Falls, Ida

23c. DATE SIGNED: 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11-28-67

24c. NAME OF CEMETERY OR CREMATORY: Buhl

24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 12-4-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: George Farmer

LICENSE NO.: E-480

FIRM NAME: Albertson-Dickard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 1 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend an Original Certificate of Birth or Death

RECEIVED
FEB 27 1968
Bureau of Vital Statistics

State of Idaho } ss.
County of Twin Falls }

Certificate No. 67-5187

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death)
for Donald E. McNelly (Name on Original Certificate) who died (Was Born or Died) on Nov 24, 1967 (Date of Event)
in Twin Falls, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by Social Sec. Card (Bible Record, Insurance Policy, Etc.) prepared on 11-26-40 (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name of Deceased	Donald E. McNelly	Donald Edwin McNelly
Social Security No.	519-56-8321	519-18-7922

Subscribed and sworn to before me this 23rd day of February, 19 68

Notary Public, residing at Twin Falls, Idaho

My commission expires 5-10-1970

(Seal)

Signed Wayne McNelly Ruffians
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

336 5th Ave E, Twin Falls, Idaho
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Twin Falls }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 23rd day of February, 19 68

Notary Public, residing at Twin Falls, Idaho.

My commission expires 5-10-1970

(Seal)

Signed Carol Frances [redacted]
(Signature of Any Credible Person)

315 [redacted]
(Street Address, City, State)

FORM DH 60-155

L. 2-20-68 BB

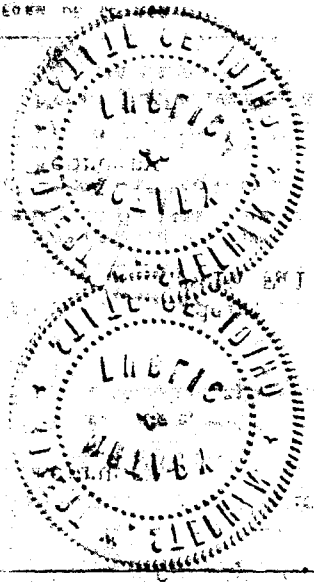

RECEIVED
FEB 5 1988

State File No. 5187
Local Reg. No. D-479
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

DEC 7 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Memorial Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Buhl
d. STREET ADDRESS (If rural, give location): R.F.D. # 4

3. NAME OF DECEASED (Type or Print)
a. (First): DONALD
b. (Middle): E.
c. (Last): MC NELLY

4. DATE OF DEATH (Month) (Day) (Year): Nov. 24, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married 1
8. DATE OF BIRTH: Jan. 19, 1922
9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Buhl, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles E. McNelly — BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Iva Hart — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 519-56-8321
17. INFORMANT'S OWN SIGNATURE: Mayme McNelly Ruffing — ADDRESS: 336 5th Ave E Twin Falls, Idaho

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): CORONARY OCCLUSION

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): CORONARY ARTERY DISEASE
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Saw only after arrival at hospital DOA, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: V. V. Pelford 525 (Degree or title) MD
23b. ADDRESS: 153 Blue Lakes N. Twin Falls, Idaho
23c. DATE SIGNED: 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 11/28/67
24c. NAME OF CEMETERY OR CREMATORY: Buhl
24d. LOCATION (City, town, or county) (State): Buhl, Idaho

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: Pamela J. Johnson
25. EMBALMER: George Farmer — LICENSE NO.: E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 11 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 1 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5188
Local Reg. No. D-414
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 132
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls (rural)
c. LENGTH OF STAY (in this place) 32 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route # 1 3/4 south 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls (rural)
d. STREET ADDRESS (If rural, give location) Route # 1 3/4 mi. south

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPH
b. (Middle) WILLIAM
c. (Last) DYE

4. DATE OF DEATH (Month) (Day) (Year) Nov. 24, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH May 22, 1889
9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dog Catcher 08
10b. KIND OF BUSINESS OR INDUSTRY City
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Dye — BIRTHPLACE unkn
14. MOTHER'S MAIDEN NAME unkn — BIRTHPLACE unkn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) - - - - - - -
16. SOCIAL SECURITY NO. 519-09-7017
17. INFORMANT'S OWN SIGNATURE x Cora Dye — ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) - - - -
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 15, 1949, *to* 11-24, 1967, *that I last saw the deceased alive on* 11-24, 1967, *and that death occurred at* 11:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE D. A. McCurdy MD 338 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 11/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 11-27-67
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 11/29/67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Dale P. Patterson — LICENSE NO. E-451
FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
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STATEMENT OF PLACE OF DEATH

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Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

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The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5189
Local Reg. No. D-708
Reg. Dist. No. 460

RECEIVED
NOV 30 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 42/ Twin Falls 002
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 42/ T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 406 Filer Avenue West

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	DAISY	BELLE	NESBITT	November 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	November 2, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Colorado
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Miles Van Winkle — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Miranda B. Young — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-34-7110B
17. INFORMANT'S OWN SIGNATURE John F. McDevitt, Twin Falls, ADDRESS Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

585X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aspiration of Stomach Contents

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Acute Cholecystitis & Surgery

DUE TO (c) Hypertension & Nephrosclerosis 15 yrs

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-21, 1959, *to* 11/24/, 1967, *that I last saw the deceased alive on* 11-24, 1967, *and that death occurred at* 9:35 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
578	M.D.	Twin Falls, Idaho	11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/27/67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
11-27-67	Pamela J. Johnson	Paul D. Reynolds	E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5190
Local Reg. No. D-772
Reg. Dist. No. 460

BIRTH NO.

NOV 30 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly 83341
d. STREET ADDRESS (If rural, give location) Box 24

3. NAME OF DECEASED (Type or Print) a. (First) LELDEN b. (Middle) C. c. (Last) CATO

4. DATE OF DEATH (Month) (Day) (Year) November 24, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH June 11, 1911

9. AGE (In years last birthday) 56 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 04

10b. KIND OF BUSINESS OR INDUSTRY farming

11. BIRTHPLACE (State or foreign country) Woodlawn, Tennessee

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME R. F. Cato BIRTHPLACE Tennessee

14. MOTHER'S MAIDEN NAME Amy Cato BIRTHPLACE Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-38-0241

17. INFORMANT'S OWN SIGNATURE Kenneth Buckler ADDRESS Twin Kimberly, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probably Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Coroner investigation only, 19—, to —, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 11:45 A m., *from the causes and on the date stated above.*

23a. SIGNATURE 588 (Degree or title) Fred D. Mayhan Justice of the Peace

23b. ADDRESS 634 Addison Ave. West T.F.

23c. DATE SIGNED 11/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11/27/67

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) Twin Falls, Idaho (State)

DATE REC'D BY LOCAL REG. 11-29-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Edgar Robertson LICENSE NO. E-507

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5191
Local Reg. No. D-425
Reg. Dist. No. 460

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
STAY (in this place) 7 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) Harral Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
OPHELIA	COX	WATSON	Nov. 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Feb. 3, 1883	84				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Ephraim, Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jordan Brady	New York	Mary Howell	New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		518-30-8366B	Clyde E. Cox	308 11th N. Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4288

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) disease with Congestive failure

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe Rheumatoid Arthritis

INTERVAL BETWEEN ONSET AND DEATH
(a) 5 Days
(b)
(c)
10-15 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10-17, 1962, *to* Nov 24, 1967, *that I last saw the deceased alive on* Nov. 23, 1967, *and that death occurred at* 8:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vern H. Anderson MD	Buhl, Ida	12-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/27/67	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-8-67	Pamela J. Johnson	George Farmer	E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-630 21

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5192
Local Reg. No. P-470
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 007 Twin Falls 000
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 128 Morningside North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	GEORGE	E.	CONRADI	11	25	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	1-16-1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper 19
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oakland, California
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Phillip Conradi	Germany	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 545-22-9606 A
17. INFORMANT'S OWN SIGNATURE Joyce A. Conrad 1950 Poplar ADDRESS Twin Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

332X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 25 Nov, 1967, to 25 Nov, 1967 p.m., *that I last saw the deceased alive on* 25 Nov, 1967, *and that death occurred at* 5:35 pm., *from the causes and on the date stated above.*

23a. SIGNATURE Dean L. Affleck 803 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 27 Nov 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 11-27-67
24c. NAME OF CEMETERY OR CREMATORY Cypress Lawn
24d. LOCATION (City, town, or county) (State) San Francisco, California

DATE REC'D BY LOCAL REG. 11-27-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Paul D. Reynolds
LICENSE NO. E-495
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 1 1967

MAR 20 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 30 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5193
Local Reg. No. D-417
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 379 Filer Ave. West 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421 b. COUNTY T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 379 Filer Ave. West

3. NAME OF DECEASED (Type or Print) a. (First) HARVEY b. (Middle) FRED c. (Last) KREPS

4. DATE OF DEATH (Month) 11- (Day) 26- (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 5-5-1927

9. AGE (In years last birthday) 40 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Artificial Inseminator

10b. KIND OF BUSINESS OR INDUSTRY 30

11. BIRTHPLACE (State or foreign country) Soda Springs, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Fred Kreps BIRTHPLACE Thurman, Iowa

14. MOTHER'S MAIDEN NAME Anna Gortcinsky BIRTHPLACE Eureka, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-22-7771

17. INFORMANT'S OWN SIGNATURE Harvey Kreps ADDRESS 379 Filer Ave Twin Falls, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

163X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma Lung — 8 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/4 19 67, *to* 11/26 19 67, *that I last saw the deceased alive on* 11/25 19 67, *and that death occurred at* 6:15 P m., *from the causes and on the date stated above.*

23a. SIGNATURE Roy O. Shaw 466 (Degree or title) M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 11/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 11-30-1967

24c. NAME OF CEMETERY OR CREMATORY Parkview Cemetery

24d. LOCATION (City, town, or county) New Plymouth, Idaho (State)

DATE REC'D BY LOCAL REG. 11-29-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER James C. Reynolds LICENSE NO. E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 1 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5194
Local Reg. No. D-418
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

RECEIVED NOV 30 1957 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 008
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mountain View Nursing Home 290

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
d. STREET ADDRESS (If rural, give location) A Street East

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ELAINE	MIRA	CARVER	November 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Sept. 26, 1930	37				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) , Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Loren Kaler BIRTHPLACE
14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 500-30-8062
17. INFORMANT'S OWN SIGNATURE Harlan G. Carver ADDRESS Eden, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

345 X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple sclerosis — INTERVAL BETWEEN ONSET AND DEATH: 12 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic pyelonephritis & renal and bladder lithiasis — 10 years
Depression — 3 years.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-4- , 1955, *to* 11/27/ , 1967, *that I last saw the deceased alive on* 11 - 27 , 19 67, *and that death occurred at* 9:14p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
B.C. Kreilkamp 296	M.D.	Twin Falls, Idaho	11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/1/67	Twin Falls Cemetery	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER James C. Reynolds	LICENSE NO.
11-29-67	Pamela Johnson	James C. Reynolds	E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5195
Local Reg. No. 0-421
Reg. Dist. No. 460

BIRTH N

Born 6-27-57

1. PLAC
a. COU
b. CITY OR TOWN
d. FULL HOS INS

1967 404

LENGTH OF STAY (in this place) hrs

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
d. STREET ADDRESS (If rural, give location) 820 Grandview Addition

eet address or location) emorial Hosp.

3. NAME OF DECEASED (Type or Print) William b. (Middle) L c. (Last) Poulton

4. DATE OF DEATH (Month) (Day) (Year) November 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	White	Never married	Sept. 27, 1957	10	2	2		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Twin Falls, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME Samuel L. Poulton, BIRTHPLACE Oakley, Idaho
14. MOTHER'S MAIDEN NAME Betty Mitton, BIRTHPLACE Oakley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) — — — —
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Samuel L. Poulton ADDRESS 820 Grandview Burley Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Enteritis and Peritonitis — 1 day
Clostridium welchii

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Diabetus mellitus
Conditions contributing to the death but not related to the disease or condition causing death. keto acidosis

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
11/29/67	As about.	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11/27 19 67 *to* 11/28, 1967, *that I last saw the deceased alive on* 11/28, 1967, *and that death occurred at* 2:00 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
E. M. Wyatt 576	MD, I	Twin Falls, Idaho	11/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	12-1-67	Riverside Cemetery	Heyburn Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-5-67	Pamela J. Johnson	Ormand Burch	E-471

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: McCULLOCH FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUN 09 2004

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5196
Local Reg. No. D-225
Reg. Dist. No. 460

RECEIVED DEC7 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 125
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hansen
STAY (in this place) 25 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Overland Ave. W. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 428 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hansen
d. STREET ADDRESS (If rural, give location) Overland Ave. W.

3. NAME OF DECEASED (Type or Print) a. (First) HARRY b. (Middle) MATHEW c. (Last) YOUNG

4. DATE OF DEATH (Month) (Day) (Year) Nov. 29, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH Aug. 4, 1887
9. AGE (In years last birthday) 80 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) blacksmith 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Minnesota
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Rufis Royal Young BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Helen Rose Vreland BIRTHPLACE Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW I 3
16. SOCIAL SECURITY NO. 519-14-7077
17. INFORMANT'S OWN SIGNATURE Roberta Aslett ADDRESS Kimberly Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 10 m

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema — 10 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ~~Sept~~ 1966, *to* present, 19___, *that I last saw the deceased alive on* 8-8-, 1967, *and that death occurred at* 12:30 m, *from the causes and on the date stated above.*

23a. SIGNATURE Werner H. Kramer M.D. (Degree or title) 243
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 1 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Dec. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-6-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Dan P. Patterson
LICENSE NO. E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-630 22

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 12 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5197
Local Reg. No. D-424
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

DEC 11 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If outside this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hosp. 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 270
b. COUNTY Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 133 East Ave. "B"

3. NAME OF DECEASED (Type or Print)
a. (First) THOMAS
b. (Middle) CLAUD
c. (Last) MILLER

4. DATE OF DEATH (Month) (Day) (Year) Nov. 30, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 12, 1891
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Old Fort, No. Carolina
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME G. F. Miller — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Mary Lou Hemphill — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 14 9784
17. INFORMANT'S OWN SIGNATURE Mrs Pansy Lee Vinyard — ADDRESS Jerome, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage c̄ left — INTERVAL BETWEEN ONSET AND DEATH 6 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hemaplegia & Aphasia
DUE TO (c) Generalized Arteriosclerosis — 3-4 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-29, 1967, *to* 11-30, 1967, *that I last saw the deceased alive on* 11-30, 1967, *and that death occurred at* 1:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE D. A. McCluskey MD 388 (Degree or title) 1
23b. ADDRESS Twin Falls Idaho
23c. DATE SIGNED 12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) (State) Jerome, Idaho

DATE REC'D BY LOCAL REG. 12-7-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5198
Local Reg. No. D-422
Reg. Dist. No. 460

BIRTH NO.

DEC 7 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hospital 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 456 West Heyburn

3. NAME OF DECEASED (Type or Print)
a. (First) WILLIAM
b. (Middle) J.
c. (Last) KING

4. DATE OF DEATH (Month) (Day) (Year) November 30,1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH February 19,1902
9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist 21
10b. KIND OF BUSINESS OR INDUSTRY Drug Store
11. BIRTHPLACE (State or foreign country) Gum Branch,North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Joseph F.King — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Bertha Mae Cox — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-09-7507
17. INFORMANT'S OWN SIGNATURE Twin Falls, Idaho — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 16 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-28, 1948, *to* 11/30/, 1967, *that I last saw the deceased alive on* 11-30, 1967, *and that death occurred at* 11:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE D.A. McCrosley MD 338 (Degree or title) M.D.
23b. ADDRESS Twin Falls,Idaho
23c. DATE SIGNED 12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/4/67
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls,Idaho

DATE REC'D BY LOCAL REG. 12-5-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER James C. Reynolds — James C. Reynolds — LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 8 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5199
Local Reg. No. 44
Reg. Dist. No. 310

Certificate of Death

RECEIVED
NOV 21 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 430 Valley 169
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural Cascade
c. LENGTH OF STAY (in this place): Life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 430
b. COUNTY: Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural Cascade
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): FRANCIS
b. (Middle): EDMUND
c. (Last): KERBY

4. DATE OF DEATH (Month) (Day) (Year): November 7, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 28, 1898
9. AGE (In years last birthday): 69 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Round Valley, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Frank M. Kerby — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Mary Jarvis — BIRTHPLACE: W. Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Marion B. Kerby — ADDRESS: Cascade, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: IMMED

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CORONARY ART. DISEASE — 2 YRS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. EPILEPSY — 1918

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): CASCADE VALLEY IDA
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1958, *to* NOV., 1967, *that I last saw the deceased alive on* NOV. 1, 1967 *and that death occurred at* 8 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: John F. Moore 376 (Degree or title) M.D.
23b. ADDRESS: CASCADE, IDA
23c. DATE SIGNED: 11/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY: Alpha Cemetery
24d. LOCATION (City, town, or county) (State): Cascade, Idaho

DATE REC'D BY LOCAL REG.: Nov-17-1967
REGISTRAR'S SIGNATURE: Myrtle H. Gardner
25. EMBALMER: Burton E. Walker — LICENSE NO.: E-386

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 24 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 13 1973

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

DEC 13 1967

Bureau of Vital Statistics

State File No. 5200
Local Reg. No. 45
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley 163
b. CITY OR TOWN Donnelly
c. LENGTH OF STAY (In this place) 63 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) at home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 430 Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Donnelly
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) JONAS b. (Middle) c. (Last) KANTOLA

4. DATE OF DEATH (Month) (Day) (Year) Nov. 18, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Jan. 3, 1887

9. AGE (In years last birthday) 80
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farming & Logging 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Kalajoki, Finland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME no record
BIRTHPLACE

14. MOTHER'S MAIDEN NAME no record
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW 1

16. SOCIAL SECURITY NO. 518-16-1724 A

17. INFORMANT'S OWN SIGNATURE John V. Goode ADDRESS Donnelly, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) coronary disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) natural

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Donnelly Valley Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *19____, to 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE Burton C Walker 583 (Degree or title) Coroner 4

23b. ADDRESS McCall, Idaho

23c. DATE SIGNED Nov. 20, '67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov 24, 1967

24c. NAME OF CEMETERY OR CREMATORY Finnish Cemetery

24d. LOCATION (City, town, or county) (State) Lakefork, Idaho

DATE REC'D BY LOCAL REG. Dec 6-1967

REGISTRAR'S SIGNATURE Myrtle A Gardner

25. EMBALMER Burton C Walker

LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-69021

DEC 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5201
Local Reg. No. 46
Reg. Dist. No. 310

BIRTH NO. RECEIVED DEC 13 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Valley 430
b. CITY OR TOWN McCall
c. LENGTH OF STAY (in this place) 3-08 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Adams
c. CITY OR TOWN New Meadows 020
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ALFRED	GEORGE	CLARK	Nov. 21, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	April 25, 1889	78				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Fish & Game Dep't & Gov't. Trapper	08	Meadows Valley, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Calrk	Iowa	Vina Elizabeth Latham	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		519-20-2726	Thelma Clark	New Meadows, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3334X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute bronchial pneumonia — INTERVAL BETWEEN ONSET AND DEATH 10 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Complete Stroke syndrome — 2 years

DUE TO (c) Generalized arteriosclerosis —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July, 1967, *to* Nov. 21, 1967, *that I last saw the deceased alive on* Nov. 20, 1967, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wayne F. Allen 006	M.D.	McCall Idaho	12-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov 25, 1967	Meadows Valley Cemetery	Meadows, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec-7-67	Myrtle M. Gardner	Burton E. Walker	E-386

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED
Bureau of Vital Statistics

State File No. 5202
Local Reg. No. 34
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Washington — NOV 29 1967 — 441
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
LENGTH OF STAY (in this place): 0-00
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Nursing Home
d. STREET ADDRESS (If rural, give location): ----

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission). a. STATE: Idaho b. COUNTY: Washington

3. NAME OF DECEASED (Type or Print): a. (First) OLGA b. (Middle) 298 c. (Last) MATHER

4. DATE OF DEATH: (Month) Nov. (Day) 7 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Dec. 2, 1894

9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Nursing 13

10b. KIND OF BUSINESS OR INDUSTRY: Nurse

11. BIRTHPLACE (State or foreign country): Genoa, Nebraska

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: T. J. Apgar — BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: ---- — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Frank D. Mather — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 331X Hypostatic Pneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) C. V. A.

DUE TO (c) Hypertension

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-31-, 1967, *to* 11-7-, 1967, *that I last saw the deceased alive on* 11-7-, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 344 M D McGeath M.D.

23b. ADDRESS: Weiser, Idaho

23c. DATE SIGNED: Nov.7,1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov.9,1967

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: Nov.7,1967

REGISTRAR'S SIGNATURE: R. Dee Thomason

25. EMBALMER: R. Dee Thomason

LICENSE NO.: E-388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under FEB 23 1968 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL -2 1986

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5203
Local Reg. No. 33
Reg. Dist. No. 320

BIRTH NO.

RECEIVED NOV 24 1967 Bureau of Vital Statistics

1. PLACE OF DEATH — a. COUNTY: Washington 441 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser — c. LENGTH OF STAY (In this place): 0-00 — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Park Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Washington — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser 441 — d. STREET ADDRESS (If rural, give location): Rt. 2

3. NAME OF DECEASED (Type or Print) — a. (First): CARRIE — b. (Middle): MARGARET 298 — c. (Last): BEECHER

4. DATE OF DEATH — (Month): Nov. — (Day): 10 — (Year): 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Feb. 19, 1882

9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Brashears, Missouri

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Lonzo Patton — BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: ---- — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Willis D Beecher — ADDRESS: Weiser, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uraemia Sec. to Arter. Hyp. — INTERVAL BETWEEN ONSET AND DEATH: 1 mo

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Arteriosclerotic Ht. Dis — 10 yrs

DUE TO (c) Gen Arteriosclerosis — 20 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes Mellitus

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) — 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1/23, 1966 *to* 11/10, 1967, *that I last saw the deceased alive on* 2/8, 1967, *and that death occurred at* 6:12 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 186 (Degree or title) — 23b. ADDRESS: Weiser, Idaho — 23c. DATE SIGNED: Nov. 10, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: Nov. 13, 1967 — 24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery — 24d. LOCATION (City, town, or county): Weiser (State): Idaho

DATE REC'D BY LOCAL REG.: Nov. 10, 1967 — REGISTRAR'S SIGNATURE: L. Dale Thomason — 25. EMBALMER: L. Dale Thomason — LICENSE NO.: E-388

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED NOV 29 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5204
Local Reg. No. 35
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Washington 441 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser — c. LENGTH OF STAY (in this place): 0-00 — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Washington — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser 441 — d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) — a. (First): CHARLES — b. (Middle): LESTER 153 — c. (Last): SALE

4. DATE OF DEATH — (Month): Nov. — (Day): 11 — (Year): 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 24, 1888

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Salina, Kansas

12. CITIZEN OF WHAT COUNTRY? Us

13. FATHER'S NAME: L. F. Sale — BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: Mary Clevenger — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: + Charles M. Sale — ADDRESS: Cambridge, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) C. V. A.

DUE TO (c) Hypertension

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-17-, 1967, *to* 11-11-, 1967, *that I last saw the deceased alive on* 11-11-, 1967, *and that death occurred at* 6:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 344 [signature] — 23b. ADDRESS: Weiser, Idaho — 23c. DATE SIGNED: Nov.11,1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: Nov.14,1967 — 24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery — 24d. LOCATION (City, town, or county): Weiser (State): Idaho

DATE REC'D BY LOCAL REG.: Nov.11,1967 — REGISTRAR'S SIGNATURE: R. Dee Thomason — 25. EMBALMER: Marshall S. Dickerson Jr. — LICENSE NO.: E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5205
Local Reg. No. 36
Reg. Dist. No. 320

BIRTH NO.

1. PLACE OF DEATH 441 NOV 29 1967
a. COUNTY: Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser
LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Weiser 441
d. STREET ADDRESS (If rural, give location): 513 E. Liberty

3. NAME OF DECEASED (Type or Print)
a. (First): HERBERT
b. (Middle): U. 153
c. (Last): KURZ

4. DATE OF DEATH: (Month) Nov. (Day) 15 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: August 18, 1906

9. AGE (In years last birthday): 61
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming 04

10b. KIND OF BUSINESS OR INDUSTRY: Farmer

11. BIRTHPLACE (State or foreign country): Kendall, Kansas

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Joseph Kurz
BIRTHPLACE: Switzerland

14. MOTHER'S MAIDEN NAME: Rosa Oppliger
BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Mrs Herb Kurz
ADDRESS: Weiser, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

150X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Esophagus — INTERVAL BETWEEN ONSET AND DEATH: 1yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-3-66, 19____, *to* 11-15-67, 19____, *that I last saw the deceased alive on* 11-15-67, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Thomas R. McDonnell, M. D. 667

23b. ADDRESS: Weiser, Idaho

23c. DATE SIGNED: Nov. 15, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Nov. 20, 1967

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Cemetery

24d. LOCATION (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: Nov. 15, 1967

REGISTRAR'S SIGNATURE: R. Dan Thomason

25. EMBALMER: Marshall Dickenson

LICENSE NO.: E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 30 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

AUG 1 1975

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5206
Local Reg. No. 706
Reg. Dist. No. 370

RECEIVED

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 — DEC 29 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luks Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise, Idaho 010
d. STREET ADDRESS (If rural, give location): 325 W. Bannock

3. NAME OF DECEASED (Type or Print)
a. (First): RUTH
b. (Middle): E
c. (Last): HAWK

4. DATE OF DEATH: (Month) 11 (Day) 19 (Year) 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Aprial 2, 1917

9. AGE (In years last birthday): 51
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Roswell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Raymond Swigert
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Elizabeth Brush
BIRTHPLACE: Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): Two 4

16. SOCIAL SECURITY NO.: 518-09-6257

17. INFORMANT'S OWN SIGNATURE: x Mary E. Hawk
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4938

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1966, 19__, *to* 11/19, 1967, *that I last saw the deceased alive on* 11/19, 19__, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 054 (Degree or title) M.D.

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 12/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 11/24/67

24c. NAME OF CEMETERY OR CREMATORY: Wilder

24d. LOCATION (City, town, or county) (State): Wilder, Idaho

DATE REC'D BY LOCAL REG.: 12-22-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature]

LICENSE NO.: E393

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 1968
JUL 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 8 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 4 1973

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

MAY 22 1973

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

NOV 21 1973

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5207
Local Reg. No. 678
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

Dec. 15 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 4104 Glenn Street

3. NAME OF DECEASED (Type or Print)
a. (First): BETTY LOU
b. (Middle): (FAIRCHILD)
c. (Last): PACK

4. DATE OF DEATH (Month) 12 (Day) 1 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 13, 1930
9. AGE (In years last birthday): 37 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Oakley, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: S. Wayne Fairchild — BIRTHPLACE: Oakley, Idaho
14. MOTHER'S MAIDEN NAME: Ethel Fox — BIRTHPLACE: Washburn, N Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-30-9107
17. INFORMANT'S OWN SIGNATURE: John H. Pack — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH 330X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral infarction

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Berry aneurysm Rt. internal carotid.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION: 11/29/67
19b. MAJOR FINDINGS OF OPERATION: Infarct of Brain.
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/26, 1967, *to* 12/1, 1967, *that I last saw the deceased alive on* 12/1 67, 19__, *and that death occurred at* 6 30 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature], M.D. 095 (Degree or title)
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 12/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/4/67
24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant [signature]
LICENSE NO.: E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUN 5 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5208
Local Reg. No. 677
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED Dec. 15 1967

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0·00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Hospital 005

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur D'Alene 281
d. STREET ADDRESS (If rural, give location): Coeur D'Alene

3. NAME OF DECEASED (Type or Print)
a. (First): Maggie
b. (Middle): Esther
c. (Last): Evans

4. DATE OF DEATH (Month) (Day) (Year): Dec. 1, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Mar. 31, 1881
9. AGE (In years last birthday): 86 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): La Farge, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Rettenhouse — BIRTHPLACE: Wisc.
14. MOTHER'S MAIDEN NAME: Jane Barnett — BIRTHPLACE: Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No.
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Hospital Records — ADDRESS: Daniel G. Gibson Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: CVA

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-26, 1962, *to* 12/1, 1967, *that I last saw the deceased alive on* 12/1, 1967, *and that death occurred at* 9:30p *m., from the causes and on the date stated above.*

23a. SIGNATURE 054 (Degree or title): [signature] M.D.
23b. ADDRESS: Boise, Idaho
23c. DATE SIGNED: 12/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12-5-67
24c. NAME OF CEMETERY OR CREMATORY: Coeur D'Alene Cemetery
24d. LOCATION (City, town, or county) (State): Coeur D'Alene, Idaho

DATE REC'D BY LOCAL REG.: 12-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512

FIRM NAME: Eldon T. Pearson
Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5209
Local Reg. No. 269
Reg. Dist. No. 370

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 DEC 6 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) D.O.A. St. Lukes 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 1515 S. Roosevelt

3. NAME OF DECEASED (Type or Print)
a. (First) Ellen
b. (Middle) Burch
c. (Last) McDonald

4. DATE OF DEATH (Month) (Day) (Year) Dec. 2, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Jan. 23, 1896
9. AGE (In years last birthday) 71
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cottonwood Falls, Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Judd L. Clark
BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Clara Ellen White
BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Vanda R Waldram
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis
INTERVAL BETWEEN ONSET AND DEATH 2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary & Cerebral Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 318 (Degree or title) MD
23b. ADDRESS 401 N. Orchard
23c. DATE SIGNED 12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-6-67
24c. NAME OF CEMETERY OR CREMATORY Morris Hill
24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 12-5-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-460
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 25 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5210
Local Reg. No. 671
Reg. Dist. No. 370

BIRTH NO.

RECEIVED Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
DEC 6 1967 3-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 203 East 43rd Street

3. NAME OF DECEASED (Type or Print): a. (First) Grace b. (Middle) Elizabeth c. (Last) Pfoser

4. DATE OF DEATH: (Month) Dec. (Day) 2 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug. 30, 1886

9. AGE (In years last birthday): 81 | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Wattsburg, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lafayette Burdick — BIRTHPLACE: ---

14. MOTHER'S MAIDEN NAME: Laura Coy-Kandell — BIRTHPLACE: ---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-28-2038

17. INFORMANT'S OWN SIGNATURE: Louis L. Burdick — 2303 N. 36th ADDRESS Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Congestive Heart Failure
DUE TO (c): Hypertensive Vascular Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Carcinoma of Endometrium

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/28, 1967, *to* 12/2, 1967, *that I last saw the deceased alive on* 12/2, 1967, *and that death occurred at* 9:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 654 (Degree or title) MD

23b. ADDRESS: 435 W Bannock, Boise

23c. DATE SIGNED: 12/5/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-5-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-6-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature] LICENSE NO. E 483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5211
Local Reg. No. 675
Reg. Dist. No. 370

BIRTH NO. 67-11368

RECEIVED Dec, NOV 15 1967 0-00
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1617 North 24th.

3. NAME OF DECEASED (Type or Print): a. (First) Baby b. (Middle) Boy c. (Last) Clark

4. DATE OF DEATH (Month) (Day) (Year): Dec. 3, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Nov. 30, 1967

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days: 1 | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: JoAnn Clark — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No.

17. INFORMANT'S OWN SIGNATURE ADDRESS: Hospital Records Gibson Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 776X Prematurity — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) none

DUE TO (c) none

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Birth, 19__, *to* death, 19__, *that I last saw the deceased alive on* 12/3, 1967, *and that death occurred at* 7:53 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Mark Myers III MD 384

23b. ADDRESS: 200 E. Bannock Boise

23c. DATE SIGNED: 12/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-7-67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 12-8-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson

LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5212
Local Reg. No. 662
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 4 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (In this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1425 Columbus 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Mass. 22
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lynn
d. STREET ADDRESS (If rural, give location): 105 Empire St.

3. NAME OF DECEASED (Type or Print): a. (First) James b. (Middle) Bertel c. (Last) Carlson

4. DATE OF DEATH: (Month) Dec. (Day) 3, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Jan. 30, 1942

9. AGE (In years last birthday): 25 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): truck driver 27

10b. KIND OF BUSINESS OR INDUSTRY: trucking

11. BIRTHPLACE (State or foreign country): Deerfield, Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Bertell Carlson
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Lucille McDonald
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): 1959 - 1963 6

16. SOCIAL SECURITY NO.: 361-34-5452

17. INFORMANT'S OWN SIGNATURE: Douglas C. Casey
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Shock - trauma
INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): self inflicted gunshot wound in head
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT 2 / SUICIDE / HOMICIDE (Specify): suicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): home 01
21c. (CITY, TOWN, OR TOWNSHIP): Boise, 13 (COUNTY): 011 Ada, (STATE): Idaho
21d. TIME OF INJURY: (Month) 12 (Day) 3 (Year) 67 (Hour) 3 a.m. /
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* AS CORONER ONLY- DID NOT SEE ALIVE, 19__, *to* __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 3 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. Parin 583 (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Drive
23c. DATE SIGNED: 12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12-4-67
24c. NAME OF CEMETERY OR CREMATORY: Pine Grove Cemetery
24d. LOCATION (City, town, or county): Lynn, Essex Co., (State): Mass.

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-460
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 4 - 1967

JAN 26 1968

AUG 6 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to supply the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician .....

Certificate of Death

STATE OF IDAHO

State File No. 5213
Local Reg. No. 197
Reg. Dist. No. 371

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 DEC 8 1967 3-59
b. CITY OR TOWN: BOISE
c. LENGTH OF STAY (in this place): 59 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO 13
b. COUNTY: ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE 011
d. STREET ADDRESS (If rural, give location): 2922 N. 36th St

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ROBERT	(NMI)	QUICK	Dec. 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married 3	1-27-99	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
PRINTER PRESSMAN 21	PRINTING	CRIPPLE CREEK, WYOMING	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
ROBERT QUICK	ENGLAND	BASHA PATTEN	IOWA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
YES WW II ONE 3	519 01 04 20	D.L. MOORE	VA CENTER, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Stroke	2 months
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Oligodendroglioma of brain	10 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Terminal bronchopneumonia	3 days

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. I attended the deceased from 10-5-67, 19__, to 12-3-67, 19__, and that death occurred at 2:30 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert C. Lewis, M.D. 597 ROVERT C LEWIS, M.D.	VA CENTER, BOISE, IDAHO	12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-6-67	Morris Hill Cemetery	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-6-67	Myrtle Palmer	Frank McLean	E-460

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 29 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5214
Local Reg. No. 674
Reg. Dist. No. 370

BIRTH NO.

DEC 13 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Ada 011 3-09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 9 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Saint Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 2713 Davis

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CECIL	O'DELL	NEWMAN	12/3/1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	WHITE	Married 3	Sept. 5, 1906	61				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Trus Joist Corp.	Steffenville, Missouri	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Burkett Newman	Virginia	Sally Belle Mitchell	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	242-05-7741	Mrs Marie Newman	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

163X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma Lungs — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Dec, 1967, *that I last saw the deceased alive on* 12-2, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
George R Baker 019	MD	121 E. Idaho Boise	12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/7/67	Syringa Gardens	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-13-67	Myrtle Palmer	Conway Grant	E 478

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: RELYEA MORTUARY

DUTIES:

DEC 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5215
Local Reg. No. 673
Reg. Dist. No. 370

Certificate of Death

RECEIVED DEC 13 1967 STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 5 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1003 North Orchard

3. NAME OF DECEASED (Type or Print)
a. (First): BEVERLY
b. (Middle): BOVEE DODS
c. (Last): GANNON

4. DATE OF DEATH (Month) 12 (Day) 3 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 13, 1920
9. AGE (In years last birthday): 47 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Stenographer 19
10b. KIND OF BUSINESS OR INDUSTRY: Met. Ins. Co.
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Jules B. Dods — BIRTHPLACE: Tooele, Utah
14. MOTHER'S MAIDEN NAME: Rozella Johnson, — BIRTHPLACE: Tooele, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 17 2277
17. INFORMANT'S OWN SIGNATURE: Arthur J. Gannon — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5811

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hepatic failure — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Lannec's Cirrhosis — 5 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Marked cirrhosis liver
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Robert Holdren MD (Degree or title) 236
23b. ADDRESS: 201 W State St
23c. DATE SIGNED: 11 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/6/67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: 12-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant — LICENSE NO. E-478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 13 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 20 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 28 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 5 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5216
Local Reg. No. 198
Reg. Dist. No. 371

CORRECTED COPY

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 29 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY ADA 011
b. CITY OR TOWN BOISE
c. LENGTH OF STAY (in this place) 49 DAYS 3-49
d. FULL NAME OF HOSPITAL OR INSTITUTION VETERANS ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY ADA
c. CITY OR TOWN BOISE 011
d. STREET ADDRESS (If rural, give location) 5207 FAIRMONT

3. NAME OF DECEASED (Type or Print) a. (First) THOMAS b. (Middle) J c. (Last) BEAUCLAIR

4. DATE OF DEATH (Month) (Day) (Year) DEC. 5, 1967

5. SEX MALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED 4

8. DATE OF BIRTH 5/17/26

9. AGE (In years last birthday) 41 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 06

10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION

11. BIRTHPLACE (State or foreign country) NEW ROCKFORD, N. DAKOTA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME LOUIS J BEAUCLAIR
BIRTHPLACE CANADA

14. MOTHER'S MAIDEN NAME MARY BOYLE
BIRTHPLACE CANADA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW II 4

16. SOCIAL SECURITY NO. 572 20 1573

17. INFORMANT'S SIGNATURE AND ADDRESS D.L. MOORE, VET. ADMIN. CENTER, BOISE IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) BRONCHOGENIC CARCINOMA

INTERVAL BETWEEN ONSET AND DEATH: 3 MONTHS

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. [redacted] I attended the deceased from Oct. 17, 19 67, to Dec. 5, 19 67, [redacted] and that death occurred at 8:25 P m., from the causes and on the date stated above.

23a. SIGNATURE FRED B HINE, M.D. (Degree or title) 597

23b. ADDRESS VET. ADMIN. CENTER BOISE, IDA

23c. DATE SIGNED 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3

24b. DATE 12-8-67

24c. NAME OF CEMETERY OR CREMATORY Newrockford Cemetery

24d. LOCATION (City, town, or county) (State) Newrockford, N. Dakota

DATE REC'D BY LOCAL REG. 12-28-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Eldon T. Pearson
Eldon T. Pearson

LICENSE NO. E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 198
Reg. Dist. No. 371

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA — DEC 12 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 49 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMIN. CENTER

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 5207 Fairmont

3. NAME OF DECEASED (Type or Print): a. (First) THOMAS; b. (Middle) J; c. (Last) BEAUCLAIR

4. DATE OF DEATH: (Month) Dec. (Day) 5, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: 5/17/26

9. AGE (In years last birthday): 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION

11. BIRTHPLACE (State or foreign country): NEW ROCKFORD, N. DAKOTA

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: LOUIS J BEAUCLAIR — BIRTHPLACE: CANDAD

14. MOTHER'S MAIDEN NAME: MARY BOYLE — BIRTHPLACE: CANADA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO.: 572 20 1573

17. INFORMANT'S OWN SIGNATURE: D.L. MOORE — ADDRESS: Vet. Admin. Center, Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchogenic carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ I attended the deceased from Oct. 17, 1967, to Nov. 5, 1967, ~~that I last saw the deceased alive on~~, and that death occurred at 8:25 P m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): FRED B HINE, M.D. Fred B. Hine MD
23b. ADDRESS: VET. ADMIN. CENTER BOISE, IDAHO
23c. DATE SIGNED: 12-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: 12-8-67
24c. NAME OF CEMETERY OR CREMATORY: Newrockford Cemetery
24d. LOCATION (City, town, or county) (State): Newrockford, N. Dakota

DATE REC'D BY LOCAL REG.: 12-8-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson
LICENSE NO.: E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DEC 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5217
Local Reg. No. 883
Reg. Dist. No. 370

BIRTH NO.

REC Dec. 1 1967

3-03 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 3½ Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 1009 Howard Street

3. NAME OF DECEASED (Type or Print)
a. (First) CLARA
b. (Middle) M.
c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year) Dec. 5, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Feb. 20, 1885

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY At home

11. BIRTHPLACE (State or foreign country) Manson, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry Arnold
BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Ella Nicholson
BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 519-60-1083

17. INFORMANT'S OWN SIGNATURE Maynel Patton ADDRESS 1009 Howard Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Peripheral + Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Mural Thrombus (Left & Rt Ventricle) — 5 days
DUE TO (c) Coronary Thrombosis. — 7 days

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 2, 1967, *to* Dec 5, 1967, *that I last saw the deceased alive on* Dec 4, 1967, *and that death occurred at* 3:00 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE Ralph Masonero. (Degree or title) 333

23b. ADDRESS 808 Galeria Dr Boise

23c. DATE SIGNED 12-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-7-67

24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 12-14-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Howell Summers — LICENSE NO. E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5218
Local Reg. No. 672
Reg. Dist. No. 370

Certificate of Death

RECEIVED DEC 11 1967 Bureau of Vital

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hsopital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 718 Village Lane

3. NAME OF DECEASED (Type or Print)
a. (First): Victor
b. (Middle): Vernon
c. (Last): Addington

4. DATE OF DEATH (Month) (Day) (Year): Dec. 5 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 29, 1896
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fingerprint officer 08
10b. KIND OF BUSINESS OR INDUSTRY: Ida. State Pen.
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Addington — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-18-9036
17. INFORMANT'S OWN SIGNATURE: Gertrude Addington — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arterio sclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 6 yr +

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): generalized arterio sclerosis — unkn
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: —

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1959, *to* 12-5, 1967, *that I last saw the deceased alive on* 12-4, 1967, *and that death occurred at* 3 Am *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. D. Forney 173 (Degree or title): MD
23b. ADDRESS: 425 Bannock St Boise
23c. DATE SIGNED: 12-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-8-1967
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 12-11-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-460
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Dec. 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5219
Local Reg. No. 682
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): DOA 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 011 Boise
d. STREET ADDRESS (If rural, give location): 711 Franklin Street

3. NAME OF DECEASED (Type or Print)
a. (First): DORIS
b. (Middle): E.
c. (Last): PYPER

4. DATE OF DEATH (Month) (Day) (Year): Dec. 5, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 8, 1897
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: At home
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Samuel Herington-Jackson, Michigan
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Mattie Babcock-Hayward, California

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 518-07-2036
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Robert H. Pyper, 216 Louisa Boise, Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac arrhythmia — INTERVAL BETWEEN ONSET AND DEATH: sudden

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic heart disease — yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Diabetes Mellitus — 2 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1967, *to* 12-5, 1967, *that I last saw the deceased alive on* 11-24, 1967, *and that death occurred at* 6:45 AM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. D. Forney 173 M.D.
23b. ADDRESS: 425 Bannock St Boise
23c. DATE SIGNED: 12-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-8-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-14-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Lowell D. Demaray
LICENSE NO.: E-509
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5220
Local Reg. No. 2820
Reg. Dist. No. 371

BIRTH NO.

RECEIVED Dec. 15 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: ADA 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: OREGON 38
b. COUNTY: MALHEUR
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NYSSA 555
d. STREET ADDRESS (If rural, give location): OWYHEE HOTEL

3. NAME OF DECEASED (Type or Print): a. (First) LIGE b. (Middle) (NMI) c. (Last) PEELER

4. DATE OF DEATH: (Month) (Day) (Year) Dec. 5, 1967

5. SEX: Male
6. COLOR OR RACE: NEGRO
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED 4
8. DATE OF BIRTH: 7-4-95
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOD CARRIER 11
10b. KIND OF BUSINESS OR INDUSTRY: CONSTRUCTION
11. BIRTHPLACE (State or foreign country): TUPELO, MISSISSIPPI
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: COMMODORE PEELER — BIRTHPLACE: UNKNOWN
14. MOTHER'S MAIDEN NAME: UNKNOWN — BIRTHPLACE: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 448 05 8499
17. INFORMANT'S OWN SIGNATURE: D.L. MOORE, VA Center, Boise, Idaho — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriolonephrosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 1, 1967, to Dec. 5, 1967 and that death occurred at 8:50 P m., from the causes and on the date stated above.

23a. SIGNATURE: Robert C. Lewis, M.D. — (Degree or title): M.D. 597
23b. ADDRESS: VET ADMIN CENTER, BOISE, IDAHO
23c. DATE SIGNED: 12-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12-8-67
24c. NAME OF CEMETERY OR CREMATORY: Nyssa Cemetery
24d. LOCATION (City, town, or county) (State): Nyssa, Oregon

DATE REC'D BY LOCAL REG.: 12-12-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Gibson Funeral Home

DUTIES:

DEC 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 24 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5221
Local Reg. No. 679
Reg. Dist. No. 370

RECEIVED Dec 15 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 17 days 3-17
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS: Belnap Rest Home, Five Mile Road for last five years

3. NAME OF DECEASED (Type or Print)
a. (First): ARCHIE
b. (Middle):
c. (Last): McIVER

4. DATE OF DEATH (Month) (Day) (Year): Dec 5, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Unk 2
8. DATE OF BIRTH: July 18, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Maintainance Engineer
10b. KIND OF BUSINESS OR INDUSTRY: St. Luke's Hosp.
11. BIRTHPLACE (State or foreign country): Turkey River, Iowa
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Angus McIver 06
BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Mary (Unknown)
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW1 3
16. SOCIAL SECURITY NO.: 539 05 3172
17. INFORMANT'S OWN SIGNATURE: X Mildred Huffman
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer Metastasis to Brain, Lungs & Bone — INTERVAL BETWEEN ONSET AND DEATH: 2 mo ±

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cancer of Prostate — 10 yr ±
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chr Emphysema

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-1, 1967, *to* Dec 5, 1967, *that I last saw the deceased alive on* Dec 5, 1967, *and that death occurred at* 4:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James G Roopingarm Cmd 242
23b. ADDRESS: 104 N Latah Boise Idaho
23c. DATE SIGNED: 12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-13-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E 478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5222
Local Reg. No. 199
Reg. Dist. No. 371

BIRTH NO.

RECEIVED
DEC 14 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 3-01
b. CITY OR TOWN: BOISE
c. LENGTH OF STAY (in this place): 1 DAY
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETERAND ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: ADA
c. CITY OR TOWN: BOISE 011
d. STREET ADDRESS (If rural, give location): 7712 Denton St

3. NAME OF DECEASED (Type or Print): a. (First) CLIFFORD; b. (Middle) P; c. (Last) COLVILLE

4. DATE OF DEATH: (Month) (Day) (Year): DEC. 6, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 4-16-99

9. AGE (In years last birthday): 68
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Analyst 08

10b. KIND OF BUSINESS OR INDUSTRY: State Highway

11. BIRTHPLACE (State or foreign country): Dazey, North Dakota

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: GEORGE COLVILLE
BIRTHPLACE: WISC.

14. MOTHER'S MAIDEN NAME: KATHRYN OWENS
BIRTHPLACE: CANDAD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WW II 4

16. SOCIAL SECURITY NO.: 539 12 9850

17. INFORMANT'S SIGNATURE: D.L. Morre
ADDRESS: D.L. MORRE, Vet. Admin. Ctr. Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute congestive failure	1 hr.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Aortic stenosis, severe	30 yrs.
DUE TO (c)	Rheumatic heart disease	50 yrs.
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Pulmonary emphysema, severe	15 yrs.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. ~~I last saw the deceased alive on~~ I attended the deceased from Dec. 6, 1967, to Dec. 6, 1967, ~~that I last saw the deceased alive on~~ and that death occurred at 6:00 A m., from the causes and on the date stated above.

23a. SIGNATURE, DEGREE OR TITLE: Roy Carpenter MD — ROY J. CARPENTER, M.D. (Degree or title) 597
23b. ADDRESS: VET. ADMIN. CENTER BOISE, IDAHO
23c. DATE SIGNED: 12-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-9-67
24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 12-14-67
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: G. W. Waters
LICENSE NO.: E-461

FIRM NAME: Clovérdale Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 12 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5223
Local Reg. No. 690
Reg. Dist. No. 370

BIRTH NO.

RECEIVED
DEC 22 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 — 3-14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2607 Cassia

3. NAME OF DECEASED (Type or Print): a. (First) (M-I C K I E) b. (Middle) DORIS MARIE c. (Last) Mc C R A E

4. DATE OF DEATH (Month) (Day) (Year): December 8, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: 2 - 17 - 1923

9. AGE (In years last birthday): 44
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Watertown, So. Dakota

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Adam Ince
BIRTHPLACE: So. Dakota

14. MOTHER'S MAIDEN NAME: unknown
BIRTHPLACE: So. Dakota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT'S OWN SIGNATURE: Grace L. Bartwell
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic adenocarcinoma 1992

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Primary site unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/25, 19 67, *to* 12/8, 19 67, *that I last saw the deceased alive on* 12/7, 19 67, *and that death occurred at* 2 4 m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] 054 (Degree or title) MD

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 12/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-20-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant

LICENSE NO.: E 478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 2 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 23 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 1 1987

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5224
Local Reg. No. 680
Reg. Dist. No. 370

BIRTH NO.

RECEIVED Dec. 1 51967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 4608 Corporal

3. NAME OF DECEASED (Type or Print): a. (First) Kirk b. (Middle) Lane c. (Last) Friend

4. DATE OF DEATH: (Month) Dec. (Day) 8 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Jan. 10, 1964

9. AGE (In years last birthday): 3 — IF UNDER 1 YEAR Months: 10 Days: 28 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Child 02

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Bernard G. Friend — BIRTHPLACE: Cleveland, Ohio

14. MOTHER'S MAIDEN NAME: Carolyn Graves — BIRTHPLACE: Caldwell, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Bernard G. Friend — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Pneumonia - croup — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan, 1964 *to* Dec 8, 1967 *that I last saw the deceased alive on* Dec 8, 1967, *and that death occurred at* 11:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Roy Borup 054 (Degree or title) M.D.

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 12/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-11-67

24c. NAME OF CEMETERY OR CREMATORY: Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-13-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. FUNERAL DIRECTOR: E-460 — ADDRESS: 419 N. 9th

Alden-Waggoner Chapel Boise, Ida.

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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State File No. 5225
Local Reg. No. 209
Reg. Dist. No. 371

RECEIVED
DEC 29 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Five Mile Nursing Home 338

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) Rt. # 5, Five Mile Rd.

3. NAME OF DECEASED (Type or Print)
a. (First) Edward
b. (Middle) Orville
c. (Last) Floyd

4. DATE OF DEATH (Month) (Day) (Year) Dec. 8, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4
8. DATE OF BIRTH Feb. 6, 1904
9. AGE (In years last birthday) 63 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY ----------
11. BIRTHPLACE (State or foreign country) Hailey, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Clato Floyd — BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Sadie Gillihan — BIRTHPLACE Whitesville, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-18-1863
17. INFORMANT'S OWN SIGNATURE Kenneth C. Floyd by [signature] — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

578X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gastrointestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH few hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/28, 1962, *to* 6/6, 1966, *that I last saw the deceased alive on* 6/6, 1966, *and that death occurred at* 11:30 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE 054 (Degree or title) [signature] M.D.
23b. ADDRESS Boise, Idaho
23c. DATE SIGNED 12/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/11/67
24c. NAME OF CEMETERY OR CREMATORY Syringa Gardens Cem.
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 12-22-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. FUNERAL DIRECTOR [signature] Alden-Waggoner Chapel
~~ADDRESS~~ E-460

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5226
Local Reg. No. 691
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 22 1967 Statistics

1. PLACE OF DEATH

a. COUNTY: Ada 011

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau 3-12

c. LENGTH OF STAY (in this place): 12 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hosp. 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 19 years 010

d. STREET ADDRESS (If rural, give location): 1017 Longmont

3. NAME OF DECEASED (Type or Print): a. (First) ALICE b. (Middle) G. c. (Last) HAYS

4. DATE OF DEATH: (Month) 12 (Day) 9 (Year) 67

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: February 14, 1885

9. AGE (In years last birthday): 82 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Fergus Falls, Minnesota

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Joseph N. La Valley — BIRTHPLACE: Montreal, Canada

14. MOTHER'S MAIDEN NAME: Unknown first name Konradt, unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 24 3059

17. INFORMANT'S OWN SIGNATURE: Laura A. Fleshman — ADDRESS:

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19 66, *to* 12/9, 1967, *that I last saw the deceased alive on* 12/9, 1967, *and that death occurred at* 7:00 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Mary L. Bell, MD. 039

23b. ADDRESS: Boise, Idaho

23c. DATE SIGNED: 12/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: December 12, 1967

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-20-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant

LICENSE NO.: E.478

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: RELYEA MORTUARY

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5227
Local Reg. No. 684
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

DEC 19 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-27
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 27 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1422 East Jefferson Street

3. NAME OF DECEASED (Type or Print)
a. (First): ELLA
b. (Middle): P.
c. (Last): LAXTON

4. DATE OF DEATH (Month) (Day) (Year): December 9, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: January 5, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife, retired
10b. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (State or foreign country): San Jose, California
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Castle — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Price — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 519-26-8823
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: 212 Mobley Dr. Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Clear cell carcinoma of kidney — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): —
DUE TO (c): —

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Metastasis to liver + bowel — 4 mos

180X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1962 *to* Dec 9, 1967, *that I last saw the deceased alive on* Dec 8, 1967, *and that death occurred at* 4.00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): O. R. Blackburn 046 MD
23b. ADDRESS: 800 La Cassia Way, Boise, Ida
23c. DATE SIGNED: Dec 11, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 12 '67
24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery
24d. LOCATION (City, town, or county) (State): Rupert, Minidoa, Idaho

DATE REC'D BY LOCAL REG.: 12-15-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Howell D. Demaray — LICENSE NO.: E-509

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 2 5 1996

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5228
Local Reg. No. 208
Reg. Dist. No. 371

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 22 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): years 1-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. # 2 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print)
a. (First): Bryant
b. (Middle): David
c. (Last): DeMOND

4. DATE OF DEATH (Month) (Day) (Year): Dec. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): ~~Marrd~~ Never Married
8. DATE OF BIRTH: 11-9-1891
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Leheigh, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William DeMOND — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Hermine Schrey — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-44-8570
17. INFORMANT'S OWN SIGNATURE: X Charles Demond — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-21-, 1964, *to* 2-21-, 1967, *that I last saw the deceased alive on* 2-21-, 1967, *and that death occurred at* 7P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Glenn C. Allen 520 — **23b. ADDRESS**: 125 E. Idaho — **23c. DATE SIGNED**: 12/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-13-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park
24d. LOCATION (City, town, or county): Boise — (State): Idaho

DATE REC'D BY LOCAL REG.: 12-21-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters — LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

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Certificate of Death

STATE OF IDAHO

State File No. 5229
Local Reg. No. 203
Reg. Dist. No. 391

BIRTH NO.

RECEIVED
DEC 21 1967
Bureau of Vital Statistics

1-02

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Nursing Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 515 Michael

3. NAME OF DECEASED (Type or Print): a. (First) MARY b. (Middle) ANNETTE c. (Last) JORGENSEN

4. DATE OF DEATH: December 10, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: April 30, 1878

9. AGE (In years last birthday): 89 | If UNDER 1 YEAR: Months / Days | If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Levan, Utah

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Albert Lester Jackman — BIRTHPLACE: Dubuque, Iowa

14. MOTHER'S MAIDEN NAME: Mary Frances Jennings — BIRTHPLACE: San Bernardino, Calif.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 529 38 6968

17. INFORMANT'S OWN SIGNATURE: Mark Jorgensen — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

170X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of breast with Metastases — INTERVAL BETWEEN ONSET AND DEATH: 15 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 1965

19b. MAJOR FINDINGS OF OPERATION: Carcinoma of breast

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 1965, *to* Dec, 1967, *that I last saw the deceased alive on* Nov 28, 1967, *and that death occurred at* 9:05A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Quentin E Howard MD 247

23b. ADDRESS: 401 Idaho St, Boise

23c. DATE SIGNED: Dec 13, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 13, 1967

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 12-20-67

REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Allen

25. EMBALMER: Conway Shant

LICENSE NO.: E478

FIRM NAME: Reiyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-630(2)

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5230
Local Reg. No. 202
Reg. Dist. No. 371

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

DEC 19 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: ADA 011 3-85
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place): 85 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VET. ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: OREGON 38
b. COUNTY: MALHEUR
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): ONTARIO 555
d. STREET ADDRESS (If rural, give location): 380 N/W 3rd St.

3. NAME OF DECEASED (Type or Print)
a. (First): BURL
b. (Middle): (NMI)
c. (Last): SNOWDEN

4. DATE OF DEATH (Month) (Day) (Year): DEC. 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 4-9-23
9. AGE (In years last birthday): 44 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): District Manager 26
10b. KIND OF BUSINESS OR INDUSTRY: Natural Gas Co.
11. BIRTHPLACE (State or foreign country): Huntington, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Bud Snowden — BIRTHPLACE: Texas
14. MOTHER'S MAIDEN NAME: Sereta Lowery — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 461 40 0234
17. INFORMANT'S OWN SIGNATURE: D.L. MOORE — ADDRESS: VA CENTER, BOISE, IDAHO

2043

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute bronchogenic pneumonia. — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Acute myelogenous leukemia. — 3½ months.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ *I attended the deceased from* Sept 19, 1967, *to* Dec 10, 1967, ~~that I last saw the deceased alive on~~ *and that death occurred at* 7:40 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): ROBERT C LEWIS, M.D. 597 — Robert C. Lewis, M.D.
23b. ADDRESS: VET. ADMIN. CENTER, BOISE, IDA
23c. DATE SIGNED: 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: Dec. 11 '67
24c. NAME OF CEMETERY OR CREMATORY:
24d. LOCATION (City, town, or county): Ontario (State): Oregon

DATE REC'D BY LOCAL REG.: 12-15-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: F. Richard Reed
LICENSE NO.: E-440

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 19 1967

DEC 21 1967

DEC 26 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 30 1981

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 22 1967 Bureau of Vital Statistics 3-06

Certificate of Death

STATE OF IDAHO

State File No. 5231
Local Reg. No. 242
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 6 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding 240
d. STREET ADDRESS (If rural, give location): 1142 Colorado St.

3. NAME OF DECEASED (Type or Print): a. (First) Lois b. (Middle) Marguerite c. (Last) Estep

4. DATE OF DEATH: (Month) Dec. (Day) 10, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 29, 1901

9. AGE (In years last birthday): 65 | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Golden City, Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lou Hall — BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Edna Leaming — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service): None 0

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: L J E Estep — ADDRESS: Gooding, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis & mild essential hypertension

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Brief hemiparesis 12/5/67

332X

19a. DATE OF OPERATION: 12/5/67

19b. MAJOR FINDINGS OF OPERATION: Incarcerated R femoral & brief indirect hernia

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/24, 1967, *to* 12/10, 1967, *that I last saw the deceased alive on* 12/10, 1967, *and that death occurred at* 2:00a m., *from the causes and on the date stated above.*

23a. SIGNATURE: R N Wyatt 545 MD (Degree or title)

23b. ADDRESS: 201 E. Bannock

23c. DATE SIGNED: 12/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-13-1967

24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery

24d. LOCATION (City, town, or county) (State): Gooding Idaho

DATE REC'D BY LOCAL REG.: 12-20-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Joe E. Walker — LICENSE NO.: E-483

FIRM NAME: Summers Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5232
Local Reg. No. 686
Reg. Dist. No. 370

RECEIVED
DEC 21 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2718 Alamo Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2718 Alamo Road

3. NAME OF DECEASED (Type or Print): a. (First) Perry b. (Middle) D. c. (Last) James

4. DATE OF DEATH: (Month) Dec. (Day) 11, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: May 2, 1900

9. AGE (In years last birthday): 67
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): produce dealer 30

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Nassau, Greece

12. CITIZEN OF WHAT COUNTRY?: Greece

13. FATHER'S NAME: James Chachas
BIRTHPLACE: Greece

14. MOTHER'S MAIDEN NAME: Mary
BIRTHPLACE: Greece

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-46-1660

17. INFORMANT'S OWN SIGNATURE: x Mrs Perry James
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Probable Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: brief

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* AS CORONER ONLY--DID NOT SEE ALIVE, 19__, *to* __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: E. Paris
583 (Degree or title): Coroner 4

23b. ADDRESS: 3720 Meadow Dr., Boise, Ida.

23c. DATE SIGNED: 12/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/15/1967

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-21-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. FUNERAL DIRECTOR: Alden-Waggoner Chapel

ADDRESS: E-460 Boise, Idaho

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

DEC 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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State File No. 5233
Local Reg. No. 727
Reg. Dist. No. 370

RECEIVED JAN 10 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 2-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Conv. Center, Boise, Ida 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 4811 Alamosa

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle): M.
c. (Last): BROWN

4. DATE OF DEATH (Month) (Day) (Year): Dec. 12, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Nov. 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months 0, Days 16 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: retired Carpenter
11. BIRTHPLACE (State or foreign country): Danathon, Missouri
12. CITIZEN OF WHAT COUNTRY?: us

13. FATHER'S NAME: William Brown — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Mary E. Denning — BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 525-12-0612 A
17. INFORMANT'S OWN SIGNATURE: Mrs F.F. Brockhoff — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Saddle Embolis of Aorta	72 hrs
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Vascular Fibrillation	10 yrs
DUE TO (c)	Antero Sclerotic Cordis Vascular Dis	30 yrs
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Senile Dementia	20 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/30/67, 19__, *to* 12/12/67 19__, *that I last saw the deceased alive on* 12/12/67, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 516
23b. ADDRESS: 1703 Hill Road, Boise
23c. DATE SIGNED: 12/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise, Ada Idaho

DATE REC'D BY LOCAL REG.: Jan. 5, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 24 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name, in addition to giving the source of information.

OCT 21 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 3 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 31 1980

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

FEB 08 2005

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5234
Local Reg. No. 681
Reg. Dist. No. 270

RECEIVED Dec. 1 5 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1617 North 12th. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Benton 003
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Corvallis 555
d. STREET ADDRESS (If rural, give location): 416 North 2nd.

3. NAME OF DECEASED (Type or Print): a. (First) Diona b. (Middle) A. c. (Last) Abbe

4. DATE OF DEATH: (Month) Dec. (Day) 12, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Sept. 17, 1883

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Corvallis, Oregon

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles H. Felton
BIRTHPLACE: Minn.

14. MOTHER'S MAIDEN NAME: Katie A. Sargent
BIRTHPLACE: Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes, give war or dates of service): ----------

16. SOCIAL SECURITY NO.: 544-36-1545

17. INFORMANT'S OWN SIGNATURE: Mrs Roy Murphy
ADDRESS: Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Stroke 334.X
INTERVAL BETWEEN ONSET AND DEATH: 1 wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Hypertension

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* 12/12/67, *that I last saw the deceased alive on* 12/10, 1967, *and that death occurred at* 4:30 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Orv Barry 054 (Degree or title): M.D

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 12/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 12-13-67

24c. NAME OF CEMETERY OR CREMATORY: Corvallis Cemetery

24d. LOCATION (City, town, or county) (State): Corvallis, Oregon

DATE REC'D BY LOCAL REG.: 12-13-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson Eldon T. Pearson

LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5235
Local Reg. No. 708
Reg. Dist. No. 370

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 011 DEC 29 1967
a. COUNTY Ada 3-04
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
LENGTH OF STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 011 Boise
d. STREET ADDRESS (If rural, give location) 1624 North 30th St.

3. NAME OF DECEASED (Type or Print) a. (First) EVELYN b. (Middle) G. c. (Last) SHOCKEY

4. DATE OF DEATH (Month) (Day) (Year) December 13, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH Mar. 27, 1888
9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife p/ retired
10b. KIND OF BUSINESS OR INDUSTRY at home.
11. BIRTHPLACE (State or foreign country) Sedan, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Andrew Jackson Gidney, BIRTHPLACE Scott Co., Ill.
14. MOTHER'S MAIDEN NAME Mary Jane Fowler, BIRTHPLACE Polk Co., Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) - - -
16. SOCIAL SECURITY NO. 518-14-2637
17. INFORMANT'S OWN SIGNATURE Mrs. Deena Arterburn ADDRESS Box 72 Council, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic hl disease — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* at time of death, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 2:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE David A. Wells 557 (Degree or title)
23b. ADDRESS 110 N. Latah St. Boise, Idaho
23c. DATE SIGNED 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE 12-16-67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-26-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER F. Richard Reed
LICENSE NO. E-440

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 26 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5236
Local Reg. No. 205
Reg. Dist. No. 371

RECEIVED
DEC 22 1967
Bureau of Vital Statistics

BIRTH NO. 3-08

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE,
c. LENGTH OF STAY (in this place) 8 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE 011
d. STREET ADDRESS (If rural, give location) 2001 North 18th

3. NAME OF DECEASED (Type or Print) a. (First) JAMES b. (Middle) E c. (Last) KELLY

4. DATE OF DEATH (Month) (Day) (Year) DEC. 13, 1967

5. SEX Male

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) DIVORCED 4

8. DATE OF BIRTH 10-19-88

9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ELECTRICIAN 21

10b. KIND OF BUSINESS OR INDUSTRY ELECTRICAL

11. BIRTHPLACE (State or foreign country) HORSESHOE BEND, IDAHO

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME SOLOMON KELLY
BIRTHPLACE ILLINOIS

14. MOTHER'S MAIDEN NAME LORENA OSGOOD
BIRTHPLACE ILLINOIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes, give war or dates of service) WW I 3

16. SOCIAL SECURITY NO. 535 07 1797

17. INFORMANT'S OWN SIGNATURE D.L. MOORE
ADDRESS Vet. Admin. Center, Boise, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 8 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Pneumonectomy for Ca, lung — 8 weeks

DUE TO (c) Pulmonary emphysema — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I attended the deceased from Dec. 5, 1967, to Dec. 13, 1967, and that death occurred at 10:40A m., from the causes and on the date stated above.

23a. SIGNATURE GLENN Q VOYLES, M.D. (Degree or title) 544

23b. ADDRESS VA CENTER, BOISE, IDAHO

23c. DATE SIGNED 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Dec. 15, 1967

24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery

24d. LOCATION (City, town, or county) Boise (State) Idaho

DATE REC'D BY LOCAL REG. 12-20-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER

LICENSE NO. E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 24 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5237
Local Reg. No. 747
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 4703 Kootenai

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GRACE	M.	WILES	12	14	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months	Days	If under 24 hrs.: Hours	Min.
Female	White	Widowed 2	9/19/1879	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Milford, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Humphrey	No record	Jennie Adams	No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	None	Jacie E. Wiles	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

33 IX

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CVA

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12/14, 1967, *to* 12/14, 1967, *that I last saw the deceased alive on* 12/14, 1967, *and that death occurred at* 10:25 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] 054 (Degree or title) M.D.	[signature]	1/19/68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/20/67	Salt Lake City Cemetery	Salt Lake City, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 23, 1968	Myrtle Palmer	Conway Grant	E 478

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: RELYEA MORTUARY

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 22 1967 Bureau of Vital Statistics 3-14

Certificate of Death

343-4281

STATE OF IDAHO

State File No. 5238
Local Reg. No. 693
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell 141
d. STREET ADDRESS (If rural, give location) Route #6

3. NAME OF DECEASED (Type or Print)
a. (First) Magdalena
b. (Middle) Dorothea
c. (Last) Lightfield

4. DATE OF DEATH (Month) (Day) (Year) Dec. 14, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 23, 1886
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY --
11. BIRTHPLACE (State or foreign country) Rochester, Wisconsin
12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME Fredrick Beguhl — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Amelia Baumgart — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) --
16. SOCIAL SECURITY NO. 504-42-8561B
17. INFORMANT'S OWN SIGNATURE Alfred J Lightfield Sr. — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1538 Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 1 YR.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~(b)~~ Hepatic & Pulmonary
~~DUE TO (c)~~ adeno Carcinoma Colon

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. osteo arthritis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1962, *to* Dec 14, 1967, *that I last saw the deceased alive on* Dec 14, 1967, *and that death occurred at* 2 AM *from the causes and on the date stated above.*

23a. SIGNATURE John E. Cipparel 094 (Degree or title) MD
23b. ADDRESS 311-Idaho St-Boise
23c. DATE SIGNED 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-16-67
24c. NAME OF CEMETERY OR CREMATORY Joplin Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 12-21-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-460

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alden-Waggoner Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5239
Local Reg. No. 192
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 001 — 3-09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — c. LENGTH OF STAY (in this place): 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding — 240
d. STREET ADDRESS (If rural, give location): 726 8th Ave. East

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Nina	Severe	Kelly	Dec. 15, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Cau.	Widowed 2	Feb. 10, 1873	94		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Grantsville, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lyman Severe	Unknown	Melina	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Lonnie Kelly — ADDRESS: Gooding Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7030

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Cardiac decompensation	12-13-67
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerosis. (~~Fracture 4 days~~)	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Fracture rt. hip (femoral neck)	12-6-67

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 01 Home
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 011 (STATE): Boise, Ada
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12 - 6 - 67 a m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fall in home

22. *I hereby certify that I attended the deceased from* 12-6, 1967, *to* 12-15-, 1967, *that I last saw the deceased alive on* 12-15, 1967, *and that death occurred at* 4:20 m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. W. Shaw 468 (Degree or title)
23b. ADDRESS: 2121 College Blvd.
23c. DATE SIGNED: 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-18-1967
24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery
24d. LOCATION (City, town, or county) (State): Gooding, Idaho

DATE REC'D BY LOCAL REG.: 12-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eddie G. Leach
LICENSE NO.: E-511
FIRM NAME: Thompson Chapel-Gooding, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JUL 18 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 9 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Hair 425 W Bannock

Certificate of Death

STATE OF IDAHO

State File No. 5240
Local Reg. No. 685
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 21 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give TOWNSHIP): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 6503 Russett

3. NAME OF DECEASED (Type or Print)
a. (First): VIRGIL
b. (Middle): K.
c. (Last): POTTER

4. DATE OF DEATH (Month) (Day) (Year): 12 15 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: September 16, 1911
9. AGE (In years last birthday): 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Self Employed 11
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Carter, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Virgil C. Potter — BIRTHPLACE: No Record
14. MOTHER'S MAIDEN NAME: Ruby Kiel — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): no 0
16. SOCIAL SECURITY NO.: 518 24 4003
17. INFORMANT'S OWN SIGNATURE: Lorena O Potter — ADDRESS:

260X

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Hypertensive Vascular Disease — several years
DUE TO (c): Diabetes mellitus. — several years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1967, *to* Dec 15, 1967, *that I last saw the deceased alive on* Dec 15, 1967, *and that death occurred at* 1:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Walter H. Hair 654 (Degree or title) MD
23b. ADDRESS: 425 W. BANNOCK, BOISE
23c. DATE SIGNED: 12/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 12/18/67
24c. NAME OF CEMETERY OR CREMATORY: Crematory
24d. LOCATION (City, town, or county) (State): Mt. View, Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-20-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant — Conway Grant
LICENSE NO.: E 478

Federal Security Agency
United States Public Health Service
Form DH-63071 Helen Olson
FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 22 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5241
Local Reg. No. 696
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 407 South 5th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 407 South 5th

3. NAME OF DECEASED (Type or Print): a. (First) Fannie; b. (Middle); c. (Last) Lockerby

4. DATE OF DEATH: (Month) Dec. (Day) 15 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Feb. 16, 1885

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Minn.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Clarence Edward Thayer — BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Henrietta Vieth — BIRTHPLACE: Minn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 530-14-0525A

17. INFORMANT'S OWN SIGNATURE ADDRESS: Clarence E. Conway

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Probable coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: brief

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* AS CORONER ONLY — DID NOT SEE ALIVE, 19__, *to* __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 8:30 PM., *from the causes and on the date stated above.*

23a. SIGNATURE: Paris 583 (Degree or title): Coroner 4/

23b. ADDRESS: 3720 Meadow Dr., Boise, Idaho

23c. DATE SIGNED: 12/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/19/67

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-21-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Paul Waggoner — LICENSE NO.: E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5242
Local Reg. No. 212
Reg. Dist. No. 371

RECEIVED DEC 29 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 209 E. 44th St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 209 E. 44th St.

3. NAME OF DECEASED (Type or Print)
a. (First): Leslie
b. (Middle): D.
c. (Last): Shellworth

4. DATE OF DEATH (Month) (Day) (Year): Dec. 16, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 21, 1906
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Accountant 19
10b. KIND OF BUSINESS OR INDUSTRY: Tax
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: J. L. Shellworth — BIRTHPLACE: Comanche, Tex.
14. MOTHER'S MAIDEN NAME: Fanny Dickinson — BIRTHPLACE: Chicago, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-10-3497
17. INFORMANT'S OWN SIGNATURE: X Grace S. Snyder — ADDRESS:

4221

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Probable cardiac insufficiency — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Probable cirrhosis of liver

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* AS CORONER ONLY--DID NOT SEE ALIVE, *19*__, *to* __, *19*__, *that I last saw the deceased alive on* __, *19*__, *and that death occurred at* ICA *m., from the causes and on the date stated above.*

23a. SIGNATURE: D. Paris 583 (Degree or title): Coroner 4
23b. ADDRESS: 3720 Meadow Dr., Boise, Ida.
23c. DATE SIGNED: 12/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/26/67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-29-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-460

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 29 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5243
Local Reg. No. 704
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH 011 1-03
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2627 Broadway

3. NAME OF DECEASED (Type or Print)
a. (First): Margaret
b. (Middle):
c. (Last): Vertrees

4. DATE OF DEATH (Month) (Day) (Year): Dec. 16, 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Oct. 13, 1881

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months 2, Days 3
IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): San Antonio, Texas

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Lawson Camp, BIRTHPLACE: Alabama

14. MOTHER'S MAIDEN NAME: Frances Mills, BIRTHPLACE: Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Edith V. Wilde ADDRESS: 2627 Broadway Boise Ida.

18. CAUSE OF DEATH 4500
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure Uncorporated — INTERVAL BETWEEN ONSET AND DEATH: 24 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Vascular Disease — 20 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Multiple Ca of Face — 20 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/11/64, 19__, *to* 12/16/67, 19__, *that I last saw the deceased alive on* 12/16/67, 19__, *and that death occurred at* 11:36 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 516 (Degree or title)

23b. ADDRESS: 1703 Hill Road, Boise

23c. DATE SIGNED: 12/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Dec. 20, 1967

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery

24d. LOCATION (City, town, or county): Burley (State): Idaho

DATE REC'D BY LOCAL REG.: 12-22-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature]

LICENSE NO.: E-422

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Alden-Waggoner Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5211
Local Reg. No. 208
Reg. Dist. No. 371

BIRTH NO.

RECEIVED DEC 22 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: ADA 01 — 1-08
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE Bureau of V[illegible]
c. LENGTH OF STAY (in this place): 2932 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: VETERANS ADMINISTRATION CENTER

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: IDAHO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): PIERCE 250
d. STREET ADDRESS (If rural, give location): CLEARWATER XHOTEL

3. NAME OF DECEASED (Type or Print): a. (First) XXXXXX JACK b. (Middle) J c. (Last) O'BRIEN 004

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 16, 1967

5. SEX: Male

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2

8. DATE OF BIRTH: 12-23-90

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LOGGER 17

10b. KIND OF BUSINESS OR INDUSTRY: LUMBERING

11. BIRTHPLACE (State or foreign country): MANISTIQUE, MICHIGAN

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: MAURICE O'BRIEN — BIRTHPLACE: CANDADA

14. MOTHER'S MAIDEN NAME: MARY BLACK — BIRTHPLACE: CANADA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW II 4

16. SOCIAL SECURITY NO.: 518 01 1885

17. INFORMANT'S OWN SIGNATURE: D.L. Moore — ADDRESS: VET. ADMIN. CENTER, BOISE, IDA

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary emphysema — INTERVAL BETWEEN ONSET AND DEATH: 11 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 20, 1959, to Dec. 16, 1967 [illegible] and that death occurred at 3:50 P m., from the causes and on the date stated above.

23a. SIGNATURE: O. F. SWINDELL, M.D. 518 (Degree or title) — O. F. Swindell

23b. ADDRESS: VA CENTER, BOISE, IDAHO

23c. DATE SIGNED: 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 19, 1967

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 12-20-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: F. Willard Reed — LICENSE NO.: E-440

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5245
Local Reg. No. 707
Reg. Dist. No. 370

RECEIVED DEC 27 1967 Bureau of V.S. 3-01

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 1515 Highland Street

3. NAME OF DECEASED (Type or Print)
a. (First) GEORGE
b. (Middle) CLAYTON
c. (Last) WALKER

4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 3, 1888

9. AGE (In years last birthday) 79
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Broker - Insurance, Bonding 30

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Rising Sun, Indiana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Dennis E. Walker, Rising Sun, Ind
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Isabelle Rank Freeport, Illinois
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 518-07-4331

17. INFORMANT'S OWN SIGNATURE Nora C. Walker
ADDRESS 1515 Highland Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 177X Ca of prostate gland

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) metastasis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1966, 19__, *to* Dec 17, 1967, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE Orl Hopkinson 704 (Degree or title)

23b. ADDRESS 401 Idaho St

23c. DATE SIGNED 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-20-67

24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 12-27-67

REGISTRAR'S SIGNATURE Myrtle Palmer by Helen Olsen

25. EMBALMER Geo E. Walker

LICENSE NO. E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 27 1961

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5246
Local Reg. No. 694
Reg. Dist. No. 370

BIRTH NO.

RECEIVED DEC 22 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 011 Ada 3-15
b. CITY OR TOWN Boise
c. LENGTH OF STAY (in this place) 15 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 8425 Vincent

3. NAME OF DECEASED (Type or Print)
a. (First) Ida
b. (Middle) Gertrude Jacoby
c. (Last) Friend

4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH June 10, 1879

9. AGE (In years last birthday) 88
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-keeper 01

10b. KIND OF BUSINESS OR INDUSTRY Whitefish for Priest

11. BIRTHPLACE (State or foreign country) Cambridge, Minn

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Philip Jacoby
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Gertrude Bruhl
BIRTHPLACE Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE John Jacoby
ADDRESS Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma Stomach

INTERVAL BETWEEN ONSET AND DEATH: 1 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary Embolus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION Carcinoma Stomach

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-2, 1967, *to* 12-17, 1967, *that I last saw the deceased alive on* 12-17, 1967, *and that death occurred at* 3:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 268 (Degree or title)

23b. ADDRESS Boise Idaho

23c. DATE SIGNED 12-19

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-21-67

24c. NAME OF CEMETERY OR CREMATORY Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 12-20-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Eldon T. Pearson
Eldon T. Pearson
LICENSE NO. E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5247
Local Reg. No. 699
Reg. Dist. No. 370

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 011 Ada — DEC 26 1967 3-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 2½ Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 517 Idaho Street

3. NAME OF DECEASED (Type or Print) — a. (First) EVERETT — b. (Middle) M. — c. (Last) BEIRNES

4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Oct. 18, 1889

9. AGE (In years last birthday) 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor-Retired

10b. KIND OF BUSINESS OR INDUSTRY Railroad

11. BIRTHPLACE (State or foreign country) Middlesex Co., Ontario, Canada

12. CITIZEN OF WHAT COUNTRY? 123

13. FATHER'S NAME 10 — **BIRTHPLACE** Robert Beirnes - Ontario, Canada

14. MOTHER'S MAIDEN NAME — **BIRTHPLACE** Victoria Lansborough - Parkhill, Ontario, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 701-12-5810

17. INFORMANT'S OWN SIGNATURE Lorena Beirnes — ADDRESS 517 Idaho Boise, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 18 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — unkn
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1966, *to* 12-17, 1967, *that I last saw the deceased alive on* 12-17, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE W. D. Forney 173 (Degree or title) M.D. — **23b. ADDRESS** 405 Bannock Boise — **23c. DATE SIGNED** 12-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-20-67
24c. NAME OF CEMETERY OR CREMATORY Terrace Lawn Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 12-26-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Helen Allen
LICENSE NO. E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-630 Rev.

DEC 2 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 2 7 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5248
Local Reg. No. 687
Reg. Dist. No. 370

BIRTH NO.

RECEIVED STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 011 — DEC 2 1 1967

b. CITY OR TOWN: Boise — Bureau of Vital Statistics

c. LENGTH OF STAY (in this place): 0-00

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011

d. STREET ADDRESS (If rural, give location): # 81 Pershing Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Thomas — b. (Middle) I. — c. (Last) Fraser

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 17, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Oct. 2, 1889

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Molder 11

10b. KIND OF BUSINESS OR INDUSTRY: Metal Construction

11. BIRTHPLACE (State or foreign country): Edmonton, Ky.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fraser — BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 330-09-1946

17. INFORMANT'S OWN SIGNATURE: + Goldie Fraser — ADDRESS: 81 Pershing dr.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 201X Hodgkins disease — INTERVAL BETWEEN ONSET AND DEATH: 9 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* August, 1967, *to* Dec, 1967, *that I last saw the deceased alive on* Dec 16, 1967 *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: George R Baker MD (Degree or title)

23b. ADDRESS: 121 E. Idaho Boise

23c. DATE SIGNED: 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 12/18/67

24c. NAME OF CEMETERY OR CREMATORY: Moline Memorial Cem.

24d. LOCATION (City, town, or county) (State): Moline, Illinois

DATE REC'D BY LOCAL REG.: 12-21-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER:

LICENSE NO.: E-460

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 21 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5249
Local Reg. No. 207
Reg. Dist. No. 271

BIRTH NO.

RECEIVED
DEC 22 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY ADA 011 3-48
b. CITY OR TOWN BOISE
c. LENGTH OF STAY (in this place) 48 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VETERANS ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE 011
d. STREET ADDRESS (If rural, give location) 2806 N. 28th St.

3. NAME OF DECEASED (Type or Print)
a. (First) LILA
b. (Middle) DUNCAN
c. (Last) CAIN

4. DATE OF DEATH (Month) (Day) (Year) DEC. 17, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOW 2
8. DATE OF BIRTH 5/18/05
9. AGE (In years last birthday) 62
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE 01
10b. KIND OF BUSINESS OR INDUSTRY SAME
11. BIRTHPLACE (State or foreign country) BOISE, IDAHO
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME MATTHEW E DUNCAN
BIRTHPLACE ARKANSAS
14. MOTHER'S MAIDEN NAME ALICE PIERCE
BIRTHPLACE IDAHO TERRITORY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES
(If yes, give war or dates of service) WW II 4
16. SOCIAL SECURITY NO. 264 36 5683
17. INFORMANT'S OWN SIGNATURE [signature]
ADDRESS D.L. MOORE, VET ADMIN CENTER, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer of Larynx
INTERVAL BETWEEN ONSET AND DEATH: 9 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that~~ I attended the deceased from Oct. 30, 1967, to Dec. 17, 1967 ~~since on~~, and that death occurred at 3:45 P m., from the causes and on the date stated above.

23a. SIGNATURE O.F. SWINDELL, M.D. Swindell 518 (Degree or title)
23b. ADDRESS VA CENTER, BOISE, IDAHO
23c. DATE SIGNED 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-19-67
24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 12-20-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Conway Grant Conway Grant
LICENSE NO. E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Relyea Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 1968

FEB 13 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Amended Dec 29, 1967

Certificate of Death

STATE OF IDAHO

State File No. 5250
Local Reg. No. 689
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 40 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2404 State 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2404 State

3. NAME OF DECEASED (Type or Print): a. (First) Zenon b. (Middle) (Yzaguirre) c. (Last) Isaguire

4. DATE OF DEATH: (Month) (Day) (Year) December 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 26, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Livestock 04
10b. KIND OF BUSINESS OR INDUSTRY: Same
11. BIRTHPLACE (State or foreign country): New York City, New York
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Manuel Isaguire — BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Carmen Archabal — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World War 1 3
16. SOCIAL SECURITY NO.: 024-01-5708
17. INFORMANT'S OWN SIGNATURE: Hazel A. Isaguire — ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Massive Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Not attended, Dead when seen, *19____, that I last saw the deceased alive on _____, 19____, and that death occurred at* 9am Dec.17 1967 *from the causes and on the date stated above.*

23a. SIGNATURE: James H. Hawley, M.D. — (Degree or title): 216
23b. ADDRESS: 850 S. Latah
23c. DATE SIGNED: 19 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-20-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 12-19-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson
LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH 12-29-67

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
DEC 29 1967
Bureau of Vital Statistics

State of ..... } ss.
County of ..... }

Certificate No. .....

Date Filed Dec. 22, 1967

The undersigned does solemnly swear that certain facts on the certificate of Death (Birth or Death) for Zenon Yzaguirre Isagurie (Name on Original Certificate) who died (Was Born or Died) on Dec. 17, 1967 (Date of Event) in Boise (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 3c	Isagurie	Isaguire

Subscribed and sworn to before me this 29 day of December, 1967

Hazel H. Gurlberg

Notary Public, residing at Boise Idaho

My commission expires Sept. 28, 1968

(Seal)

Signed Eldon T. Pearson

(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

507½ Idaho Boise Idaho

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho } ss.
County of Ada }

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 29 day of December, 1967

Corrinne Gilbert

Notary Public, residing at Boise, Idaho

My commission expires Aug 4, 1967

(Seal)

Signed Donald R. Watkinson

(Signature of Any Credible Person)

2312 Pleasanton Boise Idaho

(Street Address, City, State)

FORM DH 60-155

12-29-67

Death

Dec. 22, 1967

Death

Dec. 17, 1967

died

Isaguirre

Isaguirre

Boise

Isaguirre

Notary Public

My Commission Expires

State of

County of

The undersigned does solemnly [illegible] that they

[illegible] to before [illegible]

Signed

[illegible]

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 689
Reg. Dist. No. 270

BIRTH NO. 42344

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada DEC 22 1967

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

Bureau of Vital Statistics

c. LENGTH OF STAY (in this place): 40 Years

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2404 State

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

d. STREET ADDRESS (If rural, give location): 2404 State

3. NAME OF DECEASED (Type or Print): a. (First) Zenon b. (Middle) (Yzaguirre) c. (Last) Isagurie

4. DATE OF DEATH (Month) (Day) (Year): Dec. 17, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: August 26, 1895

9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Livestock

10b. KIND OF BUSINESS OR INDUSTRY: Same

11. BIRTHPLACE (State or foreign country): New York City, New York

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Manuel Isaguire — BIRTHPLACE: Spain

14. MOTHER'S MAIDEN NAME: Carmen Archabal — BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I

16. SOCIAL SECURITY NO.: 024-01-5708

17. INFORMANT'S OWN SIGNATURE: Boyd E. Isagurre — ADDRESS: Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Massive Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* last attended, 19__, *to* Dec 17, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 9A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): James N Kennedy MD

23b. ADDRESS: 850 S Latah

23c. DATE SIGNED: 19 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-20-67

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: 12-19-67

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson

LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 29 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 2 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 29 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5251
Local Reg. No. 709
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 9mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boise Convalesant Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada 2-09
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) Oxford Hotel

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	George	Paul	Simmons	Dec. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	never married	Aug. 10, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
none 00	none	Logan, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Frances Simmons	Ireland	Flora May Newell	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		X Lucile E Akins	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4321 Arteriosclerotic cardio Vascular

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) disease Hypostatic pneumonia

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	407	207 North 3rd - Boise, Idaho	12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 21, 1967	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-27-67	Myrtle Palmer	Glenn W Beatty	E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5252
Local Reg. No. 703
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011
b. CITY OR TOWN Boise
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN Boise 011
d. STREET ADDRESS 519 Union (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Evalena
b. (Middle) Frances
c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) Dec. 18, 1967

5. SEX Female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Oct. 7, 1877

9. AGE (In years last birthday) 90
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Livingston Co., Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Burton Bruner
BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Louisa May Gray
BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-14-3455

17. INFORMANT'S OWN SIGNATURE Howard E. Smith
ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 7d.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease with Hypertension — — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Acute respiratory infection — 3d
Diabetes Mellitus — 10+ yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7.24, 1958, *to* 12.18, 1967, *that I last saw the deceased alive on* 12.16, 1967, *and that death occurred at* 6:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE H. L. Newcombe 387 (Degree or title) M.D.

23b. ADDRESS 5-12 N. 16th St. Boise, Idaho

23c. DATE SIGNED 12.21.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 21, 67

24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery

24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. 12-22-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Alden-Waggoner Chapel

LICENSE NO. E-460

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 2 1 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

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STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 22 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5253
Local Reg. No. 698
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada 3-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 5 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bellevue 070
d. STREET ADDRESS (If rural, give location) Box 151

3. NAME OF DECEASED (Type or Print) a. (First) Michael b. (Middle) (Joe) Joseph c. (Last) McQuade

4. DATE OF DEATH (Month) (Day) (Year) Dec. 18, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Oct. 31, 1874
9. AGE (In years last birthday) 93 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist 10
10b. KIND OF BUSINESS OR INDUSTRY U.P. Railroad
11. BIRTHPLACE (State or foreign country) Stratford, Ont. Canada
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John F. McQuade
BIRTHPLACE Ireland
14. MOTHER'S MAIDEN NAME Kathryn Flynn
BIRTHPLACE Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 331X
17. INFORMANT'S OWN SIGNATURE & ADDRESS Mrs. M. J. McQuade Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of prostate

19a. DATE OF OPERATION None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-14, 1967 *to* 12-18, 1967 *that I last saw the deceased alive on* 12-18, 1967 *and that death occurred at* 9:10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 259 (Degree or title) MD
23b. ADDRESS Boise Idaho
23c. DATE SIGNED 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-22-67
24c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery
24d. LOCATION (City, town, or county) Pocatello, Idaho (State)

DATE REC'D BY LOCAL REG. 12-21-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Eldon T. Pearson
LICENSE NO. E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 6 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 2 7 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 4 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAY 2 4 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

JUL 2 8 1972

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

NOV 2 1984

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

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The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5254
Local Reg. No. 728
Reg. Dist. No. 370

RECEIVED JAN 10 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1015 North 5th

3. NAME OF DECEASED (Type or Print): a. (First) HOWARD b. (Middle) HARRIS c. (Last) BRIGGS

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 19, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Nov. 17, 1891

9. AGE (In years last birthday): 76
If under 1 year: Months / Days
If under 1 hr.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SHIPPING CLERK 25

10b. KIND OF BUSINESS OR INDUSTRY: HARDWARE

11. BIRTHPLACE (State or foreign country): Scranton Penn.

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Everett Briggs
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: Emma Kettle
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 566 20 9594

17. INFORMANT'S OWN SIGNATURE: X Lola E. Briggs
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 14 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

332X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1952 *to* Dec 19 1967 *that I last saw the deceased alive on* Dec 16, 1967 *and that death occurred at* 3 PM *from the causes and on the date stated above.*

23a. SIGNATURE: X [illegible] 088 (Degree or title) MD
23b. ADDRESS: Boise Idaho
23c. DATE SIGNED: 12/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-21-67
24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Jan. 5 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Conway Grant Conway Grant
LICENSE NO.: E478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name, in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5255
Local Reg. No. 716
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 2 1968 1-21

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 21 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 615 South 15th

3. NAME OF DECEASED (Type or Print): a. (First) HARUNO b. (Middle) c. (Last) TANABE

4. DATE OF DEATH: (Month) Dec. (Day) 19, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
female	Japanese	widowed 2	3/9/1887	79	9	10		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife C1
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Japan
12. CITIZEN OF WHAT COUNTRY? Japan

13. FATHER'S NAME: Nakamura — BIRTHPLACE: Japan
14. MOTHER'S MAIDEN NAME: Norecord — BIRTHPLACE: Norecord

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Haruno Tanabe ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebrovascular accident	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Fall with fracture of fem	3 days
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Arteriosclerotic heart disease	1-2 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT XX SUICIDE HOMICIDE (Specify) /
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP) Boise 13 (COUNTY) Ada 011 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): a/m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Fell at home on kitchen floor

22. *I hereby certify that I attended the deceased from* Dec 2, 1967, *to* death 19___, *that I last saw the deceased alive on* 12-29 19 67 *and that death occurred at* 7:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 046 (Degree or title): MD
23b. ADDRESS: 600 La Cassia Way Boise Id
23c. DATE SIGNED: 2 Jan 68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/23/67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 1-2-68
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E-478

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 2- [redacted]

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 2 1 1996

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5256
Local Reg. No. 721
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: 011 Ada
b. CITY OR TOWN: Boise
c. LENGTH OF STAY (in this place): 64 da,
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: Baker
c. CITY OR TOWN: Halfway 555
d. STREET ADDRESS: Box 87 Rt. # 1

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Evelyn	Agnes	Ritter	Dec. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	11-17-13	53				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Waitress-Bookkeeper	Retired	LaGrande, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unk. Myrick	unk.	unk.	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		528-07-4612	Evelyn Ritter	Rt. 1 Box 87 Halfway, Ore.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 3yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of Cervix — 3yr
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 11-24, 1967, *to* 12-19, 1967, *that I last saw the deceased alive on* 12-18, 1967, *and that death occurred at* 1:15a m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Grover R Baker MD (Degree or title)	121 E. Idaho Boise	12-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Cremation	12/23/67	Mt'n. View Crematory	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-3-68	Myrtle Palmer	Leonard L. Thomas	E-443

MOUNTAIN VIEW FUNERAL HOME, BOISE

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 19 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
Bureau of Vital Statistics

Certificate of Death
STATE OF IDAHO

State File No. 5257
Local Reg. No. 710
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 DEC 29 1967 3-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1619 North 14th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13 b. COUNTY Boise
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Placerville 080
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ELIZABETH	EDNA	GALLUPE	Dec. 19, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	Aug. 25, 1872	95				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	at home	Placerville, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Ashcroft	England	Mary Johnson	Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	---	518 54 0264	Alma A. Vetter	1011 N. 12th, Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

334X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Stroke

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* never, 19___, *to* ___, 19___, *that I last saw the deceased alive on* never, 19___, *and that death occurred at* 10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
095 M. D.	548 La Cassia Dr. Boise	12/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 22, 1967	Morris Hill	Boise Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-27-67	Myrtle Palmer	Howell W. Summers	E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5258
Local Reg. No. 700
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH a. COUNTY: Ada 011 3-03	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise; 3a. LENGTH OF STAY (in this place): 3 Days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003	d. STREET ADDRESS (If rural, give location): 5712 Cassia Street

3. NAME OF DECEASED (Type or Print)	a. (First) HUGH	b. (Middle) B.	c. (Last) McWATERS	4. DATE OF DEATH (Month) (Day) (Year) Dec. 19, 1967
5. SEX: Male	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3	8. DATE OF BIRTH: Sept. 4, 1903	9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Contractor 11	10b. KIND OF BUSINESS OR INDUSTRY: McWaters Construction	11. BIRTHPLACE (State or foreign country): Pearl, Idaho	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Hugh B. McWaters	BIRTHPLACE: Nebraska	14. MOTHER'S MAIDEN NAME: Nancy Vail	BIRTHPLACE: California	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---	16. SOCIAL SECURITY NO.: 541-10-0653	17. INFORMANT'S OWN SIGNATURE: Loretta McWaters	ADDRESS	

5271

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Congestive heart failure	3 mos
ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Pulmonary Fibrosis	10 yrs
DUE TO (c)	Emphysema	"
II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.	Polycythemia Vera	1 yr

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1957, 19__, *to* Dec, 1967, *that I last saw the deceased alive on* Dec 18, 1967, *and that death occurred at* 2:00 AM *from the causes and on the date stated above.*

23a. SIGNATURE: George R Baker MD 019 (Degree or title)	23b. ADDRESS: 121 East Idaho	23c. DATE SIGNED: 12/21/67	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 12-21-67	24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery	24d. LOCATION (City, town, or county) (State): Boise, Idaho
DATE REC'D BY LOCAL REG.: 12-27-67	REGISTRAR'S SIGNATURE: Myrtle Palmer by Helen Olson	25. EMBALMER: [signature]	LICENSE NO.: E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 29 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 28 1967

FEB 9 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5259
Local Reg. No. 210
Reg. Dist. No. 371

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 29 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Valley Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2022 Ellis Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Elizabeth
b. (Middle): Brown
c. (Last): Newlin

4. DATE OF DEATH (Month) (Day) (Year): Dec. 21, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 14, 1874
9. AGE (In years last birthday): 93 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Dressmaker
10b. KIND OF BUSINESS OR INDUSTRY: Clothing
11. BIRTHPLACE (State or foreign country): Vermilion Co., Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jesse Brown 21 — BIRTHPLACE: Kentucky
14. MOTHER'S MAIDEN NAME: Rachel — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: X Peninah N. Spence — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 592X: Myocardial heart disease — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Hypertension — 5 years
DUE TO (c): Chronic nephritis — 10 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1962, *to* Dec 21, 1967, *that I last saw the deceased alive on* Dec 21, 1967, *and that death occurred at* 11:40 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Roscoe C Ward 550 MD
23b. ADDRESS: Boise. Idaho
23c. DATE SIGNED: 12-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 12/23/67
24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Crematory
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-22-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Clark M Sears
LICENSE NO.: E-460

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5260
Local Reg. No. 211
Reg. Dist. No. 371

BIRTH NO.

1. PLACE OF DEATH — DEC 29 1967
a. COUNTY: ADA 011 — 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
LENGTH OF STAY (in this place): 575 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMIN. CENTER 004

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: BANNOCK
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): POCATELLO 031
d. STREET ADDRESS (If rural, give location): 151 NORTH HAYES

3. NAME OF DECEASED (Type or Print): a. (First) ARTHUR; b. (Middle) W; c. (Last) PETERSON

4. DATE OF DEATH: (Month) (Day) (Year) DEC. 21, 1967

5. SEX: Male

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3

8. DATE OF BIRTH: 2-23-93

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LOCOMOTIVE ENGINEER 10

10b. KIND OF BUSINESS OR INDUSTRY: RAILROAD

11. BIRTHPLACE (State or foreign country): GATLAND, SWEDEN

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: SARS PETERSON
BIRTHPLACE: SWEDEN

14. MOTHER'S MAIDEN NAME: MARY STROMSTRAD
BIRTHPLACE: SWEDEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES
(If yes, give war or dates of service): WW I 3

16. SOCIAL SECURITY NO.: 519 14 1312

17. INFORMANT'S OWN SIGNATURE: D.L. MOORE — ADDRESS: D.L. MOORE, VA CENTER, BOISE, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of prostate — INTERVAL BETWEEN ONSET AND DEATH: 2 Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. [redacted] I attended the deceased from May 25, 19 67 to Dec. 21, 19 67, that [redacted] and that death occurred at 11:30A m., from the causes and on the date stated above.

23a. SIGNATURE: Wm. W. Laxson (Degree or title) 597 — WM. W LAXSON, M.D.
23b. ADDRESS: VA CENTER, BOISE, IDAHO
23c. DATE SIGNED: 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12-22-67
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: 12-22-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: J. Wirland Keel
LICENSE NO.: E-440
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 5 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a BURIAL or removal permit only after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;

(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;

(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city and street address refer to PLACE WHERE THE DEATH OCCURRED. If occurring in hospitals, maternity homes or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the deceased may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state definition. The International classification of causes of death shall be used by physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5261
Local Reg. No. 707
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Ada — 011 — DEC 29 1967 — 3-21 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 3 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital — 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise — 011
d. STREET ADDRESS (If rural, give location): 2615 Lemp

3. NAME OF DECEASED (Type or Print) — a. (First): Rose — b. (Middle): — c. (Last): Palumbo
4. DATE OF DEATH (Month) (Day) (Year): Dec. 21 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 14, 1893
9. AGE (In years last birthday): 74 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Springfield, Ohio
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leo Catanzaro — BIRTHPLACE: Italy
14. MOTHER'S MAIDEN NAME: Martha Seminario — BIRTHPLACE: Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 434
17. INFORMANT'S OWN SIGNATURE: James Palumbo — ADDRESS: Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 3 mos

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Diabetes mellitus — 1 yr

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED — WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1966, *to* 12-21, 1967, *that I last saw the deceased alive on* 12-20, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: George R Baker — 019 (Degree or title): MD
23b. ADDRESS: 121 E. Idaho Boise
23c. DATE SIGNED: 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-23-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 12-22-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — Eldon T. Pearson — LICENSE NO.: E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 19 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 27 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

AUG 21 1968

OCT 16 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 10 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5262
Local Reg. No. 729
Reg. Dist. No. 270

BIRTH NO. 2-14

1. PLACE OF DEATH
a. COUNTY ADA 001
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE
c. LENGTH OF STAY (in this place) 2 WKS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) ST ALPHONSUS HOSPITAL 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY CANYON 142
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
d. STREET ADDRESS (If rural, give location) 111 16th AVE. SOUTH

3. NAME OF DECEASED (Type or Print) a. (First) BERTINA b. (Middle) M. c. (Last) ANDERSEN

4. DATE OF DEATH (Month) (Day) (Year) DEC. 21, 1967

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) WIDOWED 2
8. DATE OF BIRTH JAN. 15, 1886
9. AGE (In years last birthday) 81 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME MAKER 01
10b. KIND OF BUSINESS OR INDUSTRY AT HOME
11. BIRTHPLACE (State or foreign country) ELBA, NEBRASKA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME J. C. CLIVER BIRTHPLACE DENMARK
14. MOTHER'S MAIDEN NAME CAROLINE NO RECORD BIRTHPLACE DENMARK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE + Mrs. Helen M. Lile ADDRESS BURNS, ORE.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary insufficiency — yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 12-15-67
19b. MAJOR FINDINGS OF OPERATION Hiatus Hernia
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-10, 1967, *to* 12-21, 1967, *that I last saw the deceased alive on* 12-21, 1967, *and that death occurred at* 10:15 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE D. B. Patterson 412 (Degree or Title) MD
23b. ADDRESS BOISE, IDAHO
23c. DATE SIGNED 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
24b. DATE 12-27-67
24c. NAME OF CEMETERY OR CREMATORY CLOVERDALE MEMORIAL PK.
24d. LOCATION (City, town, or county) (State) BOISE, IDAHO

DATE REC'D BY LOCAL REG. Jan. 8 1968
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER M. B. Shepherd
LICENSE NO. 473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 10 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5263
Local Reg. No. 213
Reg. Dist. No. 371

BIRTH NO.

RECEIVED DEC 29 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5403 Irving St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Oregon 38
b. COUNTY: 3-07
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gold Hill 555
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Betty	Lou	Smith	Dec. 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Aug. 10, 1923	44				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Parma, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William N. Heath	Soldier, Ida.	Winnyfred Eckert	Lebanon, Ore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		x Winnyfred L. Bissell	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Uterus with metastases — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* AS CORONER, 19 ONLY, to 19 - DID NOT SEE ALIVE, *that I last saw the deceased alive on* 19 *and that death occurred at* 1015P m., *from the causes and on the date stated above.*

23a. SIGNATURE		23b. ADDRESS	23c. DATE SIGNED
C. M. Harris	583 (Degree or title) Coroner 4	3720 Meadow Dr., Boise, Idaho	12/24/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	12/25/67	Medford	Medford, Jackson Co., Ore.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-29-67	Myrtle Palmer	C. E. Alden	E-299

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 29 1967

JAN 8 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 2 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5264
Local Reg. No. 741
Reg. Dist. No. 370

67-11473 RECEIVED JAN 12 1968 Bureau of Vital Statistics

BIRTH NO.

343-4481

1. PLACE OF DEATH
a. COUNTY: Ada 01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 01
d. STREET ADDRESS (If rural, give location): 1416 S. Stanley

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Warren 003
c. (Last): Wright

4. DATE OF DEATH: (Month) Dec. (Day) 22, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: Dec. 22, 1967

9. AGE (In years last birthday): -0- IF UNDER 1 YEAR Months: 0 Days: 0 IF UNDER 24 HRS. Hours: 9 Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None--infant 02

10b. KIND OF BUSINESS OR INDUSTRY: ----------

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James W. Wright BIRTHPLACE: Aberdeen, S. D.

14. MOTHER'S MAIDEN NAME: Barbara Anne Leggitt BIRTHPLACE: Wellington, Tex

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: x James W. Wright ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Severe brain damage (CNS damage) — INTERVAL BETWEEN ONSET AND DEATH: 8 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Birth anoxia
DUE TO (c): Difficult breech delivery

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: 0

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION: 0

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 22, 1967, *to* Dec 22, 1967, *that I last saw the deceased alive on* Dec 22, 1967, *and that death occurred at* 10:15 Am., *from the causes and on the date stated above.*

23a. SIGNATURE: Bert Z. Reed, MD (Degree or title) 717

23b. ADDRESS: 403 Fort Street Boise

23c. DATE SIGNED: 1-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/24/67

24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens Cem.

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Jan. 10 1968

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature] LICENSE NO.: E-460

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED DEC 29 1967 Bureau of Vital Statistics

STATE OF IDAHO

343-428

State File No. 5265
Local Reg. No. 711
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH 011
a. COUNTY Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor N. Home 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 011 Boise
d. STREET ADDRESS (If rural, give location) 1708 Michigan

3. NAME OF DECEASED (Type or Print) a. (First) Mary b. (Middle) Agnes I. c. (Last) Allen

4. DATE OF DEATH (Month) (Day) (Year) Dec. 22, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH August 14, 1891
9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Sidney, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Horace B. Ickes BIRTHPLACE Pleasantville, Pa.
14. MOTHER'S MAIDEN NAME Agnes Loftus BIRTHPLACE Wilkesbarre, Pa.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE * Alvin A. Allen ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

156X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma - liver — INTERVAL BETWEEN ONSET AND DEATH 1 + yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (possibly melanoma)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-Sept, 1966, *to* 12-22, 1967, *that I last saw the deceased alive on* 12/18, 1967 *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE W. D. Torrey 173 M.D. (Degree or title)
23b. ADDRESS 425 Bannock Boise
23c. DATE SIGNED 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/27/67
24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cemetery
24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 12-29-67
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER [signature]
LICENSE NO. E-460
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 7 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 3 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5266
Local Reg. No. 717
Reg. Dist. No. 370

Certificate of Death

RECEIVED
JAN 3 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Idaho 011 2-09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 9 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Center

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boise
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Horseshoe Bend 080
d. STREET ADDRESS (If rural, give location): Box 32

3. NAME OF DECEASED (Type or Print)
a. (First): ALMA
b. (Middle): OLENA HANSON 332
c. (Last): WOODS

4. DATE OF DEATH (Month) (Day) (Year): Dec. 23 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Jan. 27, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Jerusalem, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ole Hanson — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Olave Larson — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-56-5410
17. INFORMANT'S OWN SIGNATURE: Lena M. Janssen — ADDRESS: 414 N. 27th Boise, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Diabetes Mellitus

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 371 (Degree or title) 15
23b. ADDRESS: Boise Ida
23c. DATE SIGNED: 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 26 '67
24c. NAME OF CEMETERY OR CREMATORY: Pioneer Cemetery
24d. LOCATION (City, town, or county) (State): Horseshoe Bend, Idaho

DATE REC'D BY LOCAL REG.: 1-3-68
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E 509

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SUMMERS FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 3 - 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 2 3 1977

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5267
Local Reg. No. 714
Reg. Dist. No. 370

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO. 3-21

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN Boise
LENGTH OF STAY (in this place) 3 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Alphonsus Hosital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 1100 Broxan

3. NAME OF DECEASED (Type or Print)
a. (First) Margaret
b. (Middle)
c. (Last) Gilbert

4. DATE OF DEATH (Month) (Day) (Year) Dec. 23, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Feb. 6, 1886

9. AGE (In years last birthday) 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook Schools and Hospital

10b. KIND OF BUSINESS OR INDUSTRY 01

11. BIRTHPLACE (State or foreign country) Vale, Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Coggburn
BIRTHPLACE Mo.

14. MOTHER'S MAIDEN NAME Elisia Boston
BIRTHPLACE Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-07-9219A

17. INFORMANT'S OWN SIGNATURE C. F. Gilbert
ADDRESS Meridian

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4280

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH years —

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 27 Feb, 1963 *to* 23 Dec, 1967, *that I last saw the deceased alive on* 22 Dec, 1967, *and that death occurred at* ~~7:30 P.M.~~ AM *from the causes and on the date stated above.*

23a. SIGNATURE J. Hugh Atchley 014 (Degree or title) MD

23b. ADDRESS 401 Idaho St Boise

23c. DATE SIGNED 28 Dec 67

24a. BURIAL / CREMATION / REMOVAL (Specify) Burial

24b. DATE 12-26-67

24c. NAME OF CEMETERY OR CREMATORY Star Cemetery

24d. LOCATION (City, town, or county) (State) Star, Idaho

DATE REC'D BY LOCAL REG. 1-2-68

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Geo Jewell

LICENSE NO. E-366

FIRM NAME: Robison Chapel of the Chimes

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 - 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 1 0 1996

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 1 0 1996

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5268
Local Reg. No. 215
Reg. Dist. No. 371

BIRTH NO. RECEIVED JAN 11 1968 3-57

1. PLACE OF DEATH
a. COUNTY ADA 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) BOISE Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 57 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) VA Center, Boise, Idaho 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY POWER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) AMERICAN FALLS 390
d. STREET ADDRESS (If rural, give location) 537 Gifford

3. NAME OF DECEASED (Type or Print)
a. (First) LEWIS
b. (Middle) M
c. (Last) HAWES

4. DATE OF DEATH (Month) (Day) (Year) 12-24-67

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 11-26-17

9. AGE (In years last birthday) 50
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heavy Equip operator //

10b. KIND OF BUSINESS OR INDUSTRY F.M.C. CORP

11. BIRTHPLACE (State or foreign country) Swan Lake, Idaho

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME John Hawes
BIRTHPLACE Swan Lake, Idaho

14. MOTHER'S MAIDEN NAME Ethel J. Lewis
BIRTHPLACE Lewiston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes
(If yes, give war or dates of service) WW2 4

16. SOCIAL SECURITY NO. 518-12-8041

17. INFORMANT'S SIGNATURE AND ADDRESS Le Nora Allen, VA Center, Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic melanoma to brain. — INTERVAL BETWEEN ONSET AND DEATH: 8 Weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Melanoma of left foot. — 7 Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY Ooccur?

22. I attended the deceased from 10-28, 19 67, to 12-24-, 19 67, and that death occurred at 8:28 A m., from the causes and on the date stated above.

23a. SIGNATURE R. J. BUNGARD, M.D. 597 (Degree or title)

23b. ADDRESS VA CENTER, BOISE, IDAHO

23c. DATE SIGNED 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-28-67

24c. NAME OF CEMETERY OR CREMATORY Falls View Cemetery

24d. LOCATION (City, town or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. Jan. 9 1968

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Conway Grant

LICENSE NO. E 478

FIRM NAME: Kelsey Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

APR 23 1969
JAN 1 1 1968
MAR 13 1970
APR 20 1977
MAR 23 1981

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5269
Local Reg. No. 712
Reg. Dist. No. 370

Certificate of Death

RECEIVED
DEC 29 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 4821 Wylie Lane

3. NAME OF DECEASED (Type or Print)
a. (First): Heidi
b. (Middle): Lydia
c. (Last): Frost

4. DATE OF DEATH (Month) (Day) (Year): Dec. 24, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov. 24, 1926
9. AGE (In years last birthday): 41 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Karl Jacob Stieger — BIRTHPLACE: Switzerland
14. MOTHER'S MAIDEN NAME: Josephine Federer — BIRTHPLACE: Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-22-0869
17. INFORMANT'S OWN SIGNATURE: X Victor Arlie Frost — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema + pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) fx ribs Compd fx of mandible
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Bilat fx of femurs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT XX / **SUICIDE** / **HOMICIDE** (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 Near Meridian — (COUNTY) 010 — (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 67 12p.m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: Auto accident-hit a telephone pole

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Richard Gardner 180 (Degree or title)
23b. ADDRESS: 117 E Idaho St.
23c. DATE SIGNED: 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-28-1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-29-67
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: A. E. Alden — LICENSE NO. E-299

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Alden-Waggoner Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-11478 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5270
Local Reg. No. 742
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 JAN 12 1968
b. CITY OR TOWN (If outside corporate limits, write RURAL and give): Boise Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1819 Eldorado

3. NAME OF DECEASED (Type or Print)
a. (First): LESLIE
b. (Middle): ANN
c. (Last): HENRY

4. DATE OF DEATH (Month) 12 (Day) 24 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Baby
8. DATE OF BIRTH: December 24, 1967
9. AGE (In years last birthday): If under 1 year: Months / Days; If under 24 hrs.: Hours 2 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Eric Henry — BIRTHPLACE: Kendrick, Colorado
14. MOTHER'S MAIDEN NAME: Luella Hatch — BIRTHPLACE: Boise, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Eric G. Henry — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 776X Immaturity + Prematurity — INTERVAL BETWEEN ONSET AND DEATH: Less 24 hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-24, 1967, *to* 12-24, 1967, *that I last saw the deceased alive on* 12-20, 1967 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Carl M. [illegible] 264 MD
23b. ADDRESS: 848 La Cassa Dr.
23c. DATE SIGNED: 1/8/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/27/67
24c. NAME OF CEMETERY OR CREMATORY: Kuna Cemetery
24d. LOCATION (City, town, or county): Kuna (State): Idaho

DATE REC'D BY LOCAL REG.: Jan. 11, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E-478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5271
Local Reg. No. 723
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
STRENGTH OF DAY (in this place): 65da.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2125 State Street

3. NAME OF DECEASED (Type or Print): a. (First) Ruth b. (Middle) M c. (Last) Hackworth

4. DATE OF DEATH: (Month) Dec. (Day) 24, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: 10/12/97

9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher-Principal 12

10b. KIND OF BUSINESS OR INDUSTRY: Public Schools

11. BIRTHPLACE (State or foreign country): Piedmont Missouri

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Hackworth — BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Lula McGee — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-24-5805

17. INFORMANT'S OWN SIGNATURE: Mabel H. Christensen — ADDRESS: 742 Cypress Pocatello Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cancer generalized (primary unknown) 1962

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH: 6 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1, 1962, *to* 12/24, 1962, *that I last saw the deceased alive on* 12/23, 1967, *and that death occurred at* 7:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD 109

23b. ADDRESS: 1015 N 8th St Boise Idaho

23c. DATE SIGNED: 12/31/67

24a. BURIAL, CREMATION, REMOVAL (Specify): ENTOMBMENT

24b. DATE: 12/27/67

24c. NAME OF CEMETERY OR CREMATORY: MOUNTAIN VIEW MAUSOLEUM

24d. LOCATION (City, town, or county) (State): BOISE, IDAHO

DATE REC'D BY LOCAL REG.: Jan 3 1968

REGISTRAR'S SIGNATURE: Myrtle Palmer

EMBALMER: Richard L. Mann

LICENSE NO.: E-443

MOUNTAIN VIEW FUNERAL HOME, BOISE

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

FEB 5 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 22 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5272
Local Reg. No. 722
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1604 Garfield

3. NAME OF DECEASED (Type or Print): a. (First) LULA b. (Middle) MABEL c. (Last) BRUCE

4. DATE OF DEATH (Month) (Day) (Year): Dec. 24, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: Dec. 3, 1886

9. AGE (In years last birthday): 81
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Lincoln Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Parson
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Ida Lauretta Rogers
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 519-38-9344

17. INFORMANT'S OWN SIGNATURE: Georgia L. Shaw
ADDRESS: 1520 Garfield Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 5400 Massive Gastro intestinal hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Bleeding ulcer.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Healing myocardial infarction arteriosclerosis of kidneys

INTERVAL BETWEEN ONSET AND DEATH: 3 days / 1 week / 2-3 yrs

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES X NO

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 7, 1962 *to* Dec 24, 1967, *that I last saw the deceased alive on* Dec 24, 1967, *and that death occurred at* 2:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: C. R. Blackburn 046 (Degree or title) MD

23b. ADDRESS: 800 LaCassia Way Boise

23c. DATE SIGNED: Dec 27, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 27, 1967

24c. NAME OF CEMETERY OR CREMATORY: Terrace Lawn

24d. LOCATION (City, town, or county) (State): Ada County, Idaho

DATE REC'D BY LOCAL REG.: Jan. 3, 1968

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: [signature]

LICENSE NO.: E-483

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 9 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5273
Local Reg. No. 713
Reg. Dist. No. 370

RECEIVED
DEC 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. INSIDE CITY LIMITS? (In this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Rear of 1010 Broadway

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 011 Boise
d. STREET ADDRESS (If rural, give location) 931 Broadway

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Loraine c. (Last) Pyne

4. DATE OF DEATH (Month) (Day) (Year) Dec. 24, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH March 22, 1894

9. AGE (In years last birthday) 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 21

10b. KIND OF BUSINESS OR INDUSTRY Auto

11. BIRTHPLACE (State or foreign country) St. Francis, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME BIRTHPLACE William Anderson Pyne

14. MOTHER'S MAIDEN NAME BIRTHPLACE Linnie S. Harmon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1 3

16. SOCIAL SECURITY NO. 518-14-3004

17. INFORMANT'S OWN SIGNATURE Clifton E. Pyne ADDRESS Ketchum, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Insufficiency — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* as corroner only--DID NOT SEE ALIVE, 19__, to 19__, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* 730A *m., from the causes and on the date stated above.*

23a. SIGNATURE E W Parris 583 (Degree or title) Coroner 4

23b. ADDRESS 3720 Meadow Dr., Boise, Idaho

23c. DATE SIGNED 12/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12/27/67

24c. NAME OF CEMETERY OR CREMATORY Dry Creek Cemetery

24d. LOCATION (City, town, or county) (State) Boise, Idaho

DATE REC'D BY LOCAL REG. 12-29-67

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Earl Waggoner

LICENSE NO. E-422

FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5274
Local Reg. No. 720
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics 401

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ada County Nursing Home 300

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1011 Shamrock St.

3. NAME OF DECEASED (Type or Print)
a. (First): MARY
b. (Middle): LOUISE
c. (Last): HAGAN

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 24, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Jan. 20, 1911

9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper 19

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Fostoria, Ohio

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank L. Vance
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Edith Schwartz
BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 535-20-3959

17. INFORMANT'S OWN SIGNATURE: Mrs. Duane Calkins
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Respiratory failure — 3 hours.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Asthma, Emphysema, Bronchitis — years

DUE TO (c): Bronchiectasis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Congestive Heart failure — 2 months.

526X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 28, 1967, *to* Dec. 23, 1967, *that I last saw the deceased alive on* Dec. 23, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Robert M. Dreyer M.D. 176 (Degree or title)

23b. ADDRESS: 2010 N Cole Rd Boise

23c. DATE SIGNED: 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-28-67

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Memorial Park

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 1-2-68

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: G. W. Waters

LICENSE NO.: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 9 1963

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5275
Local Reg. No. 737
Reg. Dist. No. 370

Certificate of Death

RECEIVED
JAN 11 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Midvale 440
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): BEULAH
b. (Middle): WIGGINS
c. (Last): WILLIAMS

4. DATE OF DEATH (Month) Dec. (Day) 25 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 9, 1931
9. AGE (In years last birthday): 36 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Cambridge, Idaho
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Archie Wiggins — BIRTHPLACE: Midvale, Idaho
14. MOTHER'S MAIDEN NAME: Hazel Gertrude Skeen — BIRTHPLACE: Midvale, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: X Hazel G. Wiggins — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5810

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Post necrotic cirrhosis of liver

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Gastrointestinal hemorrhage.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/27, 1967, *to* 12/25, 1967, *that I last saw the deceased alive on* 12/25, 1967, *and that death occurred at* 7 10 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 095 (Degree or title) M.D.
23b. ADDRESS: Boise, Ida.
23c. DATE SIGNED: Dec. 25, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Dec. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Eastside Cemetery
24d. LOCATION (City, town, or county): Weiser (State): Idaho

DATE REC'D BY LOCAL REGISTRAR: Jan. 10, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Marshall L. Dickinson Jr.
LICENSE NO.: E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 11 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5276
Local Reg. No. 732
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 010
JAN 11 1968
Bureau of Vital Statistics
1-13
b. CITY OR TOWN: Eagle
c. LENGTH OF STAY (in this place): 15 years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eagle 010
d. STREET ADDRESS (If rural, give location): Across from Eagle Post Office

3. NAME OF DECEASED (Type or Print): a. (First) MAYME b. (Middle) E c. (Last) DOUGLAS

4. DATE OF DEATH: (Month) 12 (Day) 25 (Year) 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: Feb. 19, 1882

9. AGE (In years last birthday): 85 IF UNDER 1 YEAR Months: 10 Days: 6 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Joseph, Oregon

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James H. Locke BIRTHPLACE: No Record

14. MOTHER'S MAIDEN NAME: Mary Ferguson BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Mrs. Rachel Stinson ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Uremia — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

2937

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12/4, 1967, *to* 12/25, 1967, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 654 MD
23b. ADDRESS: 425 W. Bannock
23c. DATE SIGNED: 1/5/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/28/67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery
24d. LOCATION (City, town, or county): Boise (State): Idaho

DATE REC'D BY LOCAL REG.: Jan. 9, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant LICENSE NO.: E-178
FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5277
Local Reg. No. 724
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

343
4281

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 5225 Irving

3. NAME OF DECEASED (Type or Print)
a. (First): Harlan
b. (Middle): 003
c. (Last): Napier III

4. DATE OF DEATH: (Month) Dec. (Day) 25 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: April 23, 1950

9. AGE (In years last birthday): 17
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): student 03

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Harlan Napier Jr.
BIRTHPLACE: Weiser, Ida.

14. MOTHER'S MAIDEN NAME: Lorraine V. Quinter
BIRTHPLACE: Boise, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: --

17. INFORMANT'S OWN SIGNATURE: Harlan Napier
ADDRESS: Boise

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3441

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hydrocephalus

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Adequeduct Stenosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Jan, 19 67, *to* Dec, 19 67, *that I last saw the deceased alive on* 12-25, 19 67 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D. 704

23b. ADDRESS: 401 Idaho St

23c. DATE SIGNED: 1-3-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: 12/29/67

24c. NAME OF CEMETERY OR CREMATORY: Mtn. View Crematorium

24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Jan. 3, 1968

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Earl Waggoner
LICENSE NO.: E-422
FIRM NAME: Alden-Waggoner Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5278
Local Reg. No. 725
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 011 Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 111 Main Apt. 4 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise 011
d. STREET ADDRESS (If rural, give location) 111 Main Apt. 4

3. NAME OF DECEASED (Type or Print)
a. (First) Leo
b. (Middle) Earl
c. (Last) Orr

4. DATE OF DEATH (Month) (Day) (Year) Dec. 26, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced

8. DATE OF BIRTH Jan. 21, 1906

9. AGE (In years last birthday) 61
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Laborer 06

10b. KIND OF BUSINESS OR INDUSTRY Laborer

11. BIRTHPLACE (State or foreign country) Deleware, Indiana

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew Orr
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Minnie Aherns
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Daniel G. Gibson Phone Information
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5271

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Emphysema, with apparent Cardia condition — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Continued Intoxication for — weeks

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19, *to* 19, *that I last saw the deceased alive on* 19, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23a. SIGNATURE C. Harris 583 (Degree or title) Coroner

23b. ADDRESS 3720 Meadow Drive, Boise.

23c. DATE SIGNED 12-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 12-30-67

24c. NAME OF CEMETERY OR CREMATORY Memorial Park

24d. LOCATION (City, town, or county) (State) Council Bluffs, Iowa

DATE REC'D BY LOCAL REG. Jan. 3, 1968

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Daniel G. Gibson

LICENSE NO. E-400

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 25 1971

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5279
Local Reg. No. 726
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 8 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 010
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kuna
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 216 Elm Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kuna 010
d. STREET ADDRESS (If rural, give location) 216 Elm Street

3. NAME OF DECEASED (Type or Print) a. (First) Rita b. (Middle) M. c. (Last) Hailey

4. DATE OF DEATH (Month) (Day) (Year) Dec. 26, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 6, 1889
9. AGE (In years last birthday) 78 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY homemaking
11. BIRTHPLACE (State or foreign country) Bellevue, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John B. McCoy BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Harriet Hauld BIRTHPLACE Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519 10 3495
17. INFORMANT'S OWN SIGNATURE Jesse R Hailey ADDRESS Kuna

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5604

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Thrombo-embolus - cerebral

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac thrombus
DUE TO (c) Cardiac arrythmia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Superior mediastinal thyroid mass. Hiatus hernia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 11/11/67 12/10/67
19b. MAJOR FINDINGS OF OPERATION Large hiatus hernia / Thrombo embolus to right brachial artery
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 26, 1967, *to* Dec 26, 1967, *that I last saw the deceased alive on* Dec 24, 1967, *and that death occurred at* 3:00 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE J. Bolall MD 766 (Degree or title)
23b. ADDRESS 824-17th Ave S., Tampa
23c. DATE SIGNED 12/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY Kuna Cemetery
24d. LOCATION (City, town, or county) Kuna (State) Idaho

DATE REC'D BY LOCAL Jan. 5, 1968
REGISTRAR'S SIGNATURE Myrtle Palmer
25. EMBALMER Richard W. Mesenbrink
LICENSE NO. E-487

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post-office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Lessor

Certificate of Death

State File No. 5280
Local Reg. No. 740
Reg. Dist. No. 370

BIRTH NO. 3113 State RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011 JAN 11 1968 1-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 3 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Treasure Valley Manor 293

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1420 North 14th.

3. NAME OF DECEASED (Type or Print)
a. (First): Anna
b. (Middle): M.
c. (Last): Sullivan

4. DATE OF DEATH (Month) (Day) (Year): Dec. 26, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 20, 1883
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Maine
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE
14. MOTHER'S MAIDEN NAME — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.: 519-60-0114
17. INFORMANT'S OWN SIGNATURE: George Tapp — ADDRESS: Boise

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Myocardosis
DUE TO (c) Hypertension arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Cholesterosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____ *1960, to* 12/26, 1967, *that I last saw the deceased alive on* 12/25, 1967 *and that death occurred at* 4:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 306 MD
23b. ADDRESS: Boise Ida
23c. DATE SIGNED: 1/10/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-28-67
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: Jan. 11 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5281
Local Reg. No. 733
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 11 1968 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Ada 011 — 4-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 1 hour
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Luke's Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 708 McKinley

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ARNOLD		SIEBERT	Dec. 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married 3	1/28/1929	37		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 06	Commercial Janitorial Service	Atlas Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Siebert	Goodrich, Michigan	Matilda Rose	Hadley, Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	288-24-3761	Windola Siebert	

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Retroperitoneal Hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Multiple Fx spine, pelvis & Ribs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Comp Fx Elbow & Dislocation Shoulder

INTERVAL BETWEEN ONSET AND DEATH: 1-2 hrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
12/26/67	Hemorrhage	YES ☒ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
Accident	Hospital	13 Boise Ada Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
12 26 67 1445 a.m.		Fell from 3rd Floor

22. *I hereby certify that I attended the deceased from* 12-26, 19, *to* 12-26, 1967, *that I last saw the deceased alive on* 12-26, 1967, *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	125	Boise Ida	1/4/68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/29/67	Syringa Garden	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 9, 1968	Myrtle Palmer	Conway Grant	E-478

FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 12 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5282
Local Reg. No. 745
Reg. Dist. No. 370

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 19 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 2-16
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 16 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 13 Mesa Drive 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 478 Moreland

3. NAME OF DECEASED (Type or Print)
a. (First): LIZZIE
b. (Middle): MAY
c. (Last): HALE

4. DATE OF DEATH (Month) (Day) (Year): Dec. 27, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Aug. 16, 1877
9. AGE (In years last birthday): 90 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Portage, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Halford — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Emma Hoskins — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Mrs. O. A. Nielsen — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

522X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Antinio Salvosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/21, 1966, *to* 12/21, 1967, *that I last saw the deceased alive on* 12/21, 1967, *and that death occurred at* 12:45 a.m., *from the causes and on the date stated above.* 12/27/67

23a. SIGNATURE 528 (Degree or title): Jonas S Thomas Jr
23b. ADDRESS: 305 Fort St. Boise
23c. DATE SIGNED: 1/12/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: McCammon Cemetery
24d. LOCATION (City, town, or county) (State): McCammon, Bannock, Idaho

DATE REC'D BY LOCAL REG.: Jan. 16, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant — LICENSE NO. E478
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 19 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 25 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5283
Local Reg. No. 214
Reg. Dist. No. 271

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

JAN 10 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Sunset Home 235

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): Boise Sunset Home

3. NAME OF DECEASED (Type or Print)
a. (First): Nettie
b. (Middle):
c. (Last): Taylor

4. DATE OF DEATH (Month) (Day) (Year): Dec. 28, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 17, 1876
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: La Fayette Boring — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Lucinda O. Kiggins — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-62-9541
17. INFORMANT'S OWN SIGNATURE: Hazel F. Tileston — ADDRESS: Cloverdale Calif.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 36 hrs.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Cerebral Arteriosclerosis — progressing
DUE TO (c): Diabetes

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___ and that death occurred at 1:30P m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 318 (Degree or title) MD
23b. ADDRESS: 401 No Orchard, Boise, Idaho
23c. DATE SIGNED: 12-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-30-67
24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery
24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Jan. 9, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Geo Jerread
LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Anderson

Certificate of Death

STATE OF IDAHO

State File No. 5284
Local Reg. No. 743
Reg. Dist. No. 370

RECEIVED JAN 17 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011
b. CITY OR TOWN: BOISE
LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Lukes 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: [redacted]
c. CITY OR TOWN: BOISE 011
d. STREET ADDRESS (If rural, give location): 908 Clover Dr.

3. NAME OF DECEASED (Type or Print): a. (First) Myrtle; b. (Middle) Dixon; c. (Last) Anderson

4. DATE OF DEATH: (Month) 12 (Day) 29 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 10/26/1884

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months 2; Days 3
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Preston, Idaho

12. CITIZEN OF WHAT COUNTRY?: US.

13. FATHER'S NAME: Alfred Alder
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Sarah Jensen
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT'S OWN SIGNATURE: Delva D. Smith
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C. V. A.
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 4-7- , 19[illegible], *to* Dec. 29, 1967, *that I last saw the deceased alive on* 8-14 , 1967, *and that death occurred at* 11:[illegible] m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 528 (Degree or title)
23b. ADDRESS: 305 Fort St. Boise
23c. DATE SIGNED: 1/5/68

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: 1/2/68
24c. NAME OF CEMETERY OR CREMATORY: Preston City Cemetery
24d. LOCATION (City, town, or county) (State): Preston, Idaho

DATE REC'D BY LOCAL REG.: Jan. 12, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Russell C. Relyea
LICENSE NO.: E-412
FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 6 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 28 1986

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5285
Local Reg. No. 734
Reg. Dist. No. 370

RECEIVED JAN 11 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): 39 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convelesent Center 332

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 3909 Hillcrest Dr.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Elma	Collings	Harmon	12/	29/	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	9/25/1880	87	3	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Monroe, Utah
12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: David Collings — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Frances Ligonbee — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: (Mrs. S. E. (Lila B.) Whitman ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive Heart Failure — 1 wk
DUE TO (c) Arteriosclerotic Heart Disease —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1-10, 1967, *to* 12-29, 1967, *that I last saw the deceased alive on* 12-29, 1967, *and that death occurred at* ? *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
333 M. Maxwell M.D.	808 Lakeview Dr	1-6-68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1/3/68	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 9 1968	Myrtle Palmer	Russell C. Kelyea	E-412

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 0 9 1994

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5286
Local Reg. No. 715
Reg. Dist. No. 370

RECEIVED
Bureau of Vital Statistics
JAN 3 1968

BIRTH NO. 3-03

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hospital 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 313 Chester Dr.

3. NAME OF DECEASED (Type or Print): a. (First) GEORGE b. (Middle) P. c. (Last) PERRIN

4. DATE OF DEATH: (Month) (Day) (Year) Dec. 29, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 13, 1883

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): River John, Nova Scotia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edmund Perrin
BIRTHPLACE: Nova Scotia

14. MOTHER'S MAIDEN NAME: Sydonia Morrell
BIRTHPLACE: Nova Scotia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 010-07-5693A

17. INFORMANT'S OWN SIGNATURE: X Ruth P. Preble
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Emphysema
INTERVAL BETWEEN ONSET AND DEATH: yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Asthma.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-22, 1967, *to* 12-29, 1967, *that I last saw the deceased alive on* 12-28, 1967, *and that death occurred at* 24 m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. B. Patterson (Degree or title) M.D.
23b. ADDRESS: Boise
23c. DATE SIGNED: 12-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: 12-30-67
24c. NAME OF CEMETERY OR CREMATORY: Mnt. View Crematorium
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: 12-29-67
REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: G. W. Waters
LICENSE NO.: E-461

FIRM NAME: Cloverdale Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 12 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED Bureau of Vital Statistics STATE OF IDAHO

State File No. 5287
Local Reg. No. 738
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Ada 011 JAN 11 1968
b. CITY OR TOWN Boise,
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmoore 200
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Glenns Ferry,
d. STREET ADDRESS (If rural, give location) Box # 251

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Edna	Von	Hutchcraft	12	30	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Oct. 12, 1908	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
U.P. Railroad Co. 10	Clerk (store)	Simmons, Missouri	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John H. Orr	Georgia	Myrtle Cunningham	Simmons, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	478-09-5320	X Myrtle Orr	Glennsferry

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lower Abdomen & Pelvis — INTERVAL BETWEEN ONSET AND DEATH 6 mo

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinomatosis & Tumor Necrosis — Cancer of Mid Rectum — 2 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death. none

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Cancer of Mid Rectum	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 1954 *to* 12/30, 1967, *that I last saw the deceased alive on* 12/29, 1967 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Clarence Jones M.D. 267 (Degree or title)	Boise Idaho	1/2

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1-3-1968	Oakdale Cemetery	Oakdale Texas Co. Mo.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 10, 1968	Myrtle Palmer	Lowell Thompson	E-509

FIRM NAME: Summers Funeral Home Boise, Idaho.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 15 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 1 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5288
Local Reg. No. 730
Reg. Dist. No. 370

RECEIVED JAN 10 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 011 3-03
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 4125 Hillcrest Drive

3. NAME OF DECEASED (Type or Print)
a. (First): Mary
b. (Middle): B.
c. (Last): Morrison

4. DATE OF DEATH (Month) (Day) (Year): Dec. 30, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb. 18, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Boise, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George H. Brewer — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Ellen Ryan — BIRTHPLACE: Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): ----------
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Frank B. Morrison — ADDRESS: Boise

18. CAUSE OF DEATH 5271
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Empysema — 10 years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-25, 1966, *to* _____, 19__, *that I last saw the deceased alive on* 12-30, 1967, *and that death occurred at* 11 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Everett N. Jones Jr. M.D. 268
23b. ADDRESS: 318 First Nat Bank
23c. DATE SIGNED: 1-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-3-68
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: Jan. 8, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Daniel G. Gibson — LICENSE NO.: E-400

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Gibson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

SEP 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED.. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5289
Local Reg. No. 735
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 JAN 1 1 1968 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): 4 Days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 4650 Shannon

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Hilma	O.	Jensen	12	30	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 1 DAY Hours	Min.
Female	White	Married 3	3/31/1931	36	8	29		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01		Cedar City Utah	US.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Almon Hills Orton	Parowan Utah	Arvilla Day	Parowan Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			X Max N Jensen	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) metastatic adenocarcinoma of the colon — INTERVAL BETWEEN ONSET AND DEATH: 3½ yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 18 July, 1966, *to* 30 Dec, 1967, *that I last saw the deceased alive on* 29 Dec, 1967, *and that death occurred at* 12 15 Am., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J Hugh Atchley	014 MD	401 Idaho ST Boise Ida	5 Jan 68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1/4/67	Logan City Cemetery	Logan, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 9 1968	Myrtle Palmer	Russell C. Relyea	E 412

FIRM NAME: RELYEA MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 1 1 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. FEB 5 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to MAY 6 1975

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased. JAN 23 1979
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED; SEP 23 1980
(d) Alter a certificate on file in the office of a local registrar. JAN 22 1996

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5290
Local Reg. No. 739
Reg. Dist. No. 270

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
LENGTH OF STAY (in this place): D O A
d. FULL NAME OF HOSPITAL OR INSTITUTION: St Alphonsus 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett 231
d. STREET ADDRESS (If rural, give location): Route 1 Box 300

3. NAME OF DECEASED (Type or Print): a. (First) Herbert b. (Middle) Louis c. (Last) George Pohl

4. DATE OF DEATH: (Month) (Day) (Year) December 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
male	white	married 3	June 14, 1909	58	6	16		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Kiln operator 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Thayer, Nebraska
12. CITIZEN OF WHAT COUNTRY? SA

13. FATHER'S NAME: Ferdinand Pohl — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Elfran Louise Reetz — BIRTHPLACE: Thayer, Neb.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 506-12-7978
17. INFORMANT'S OWN SIGNATURE: Mr Herbert Pohl — ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: Norman D. Sower 780 (Degree or title)
23b. ADDRESS: 312 W. Idaho Boise
23c. DATE SIGNED: 1/4/68

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Jan. 3, 1968
24c. NAME OF CEMETERY OR CREMATORY: Emmett Cemetery
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Jan. 10, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Walter F. Potter
LICENSE NO.: E-445
FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. JAN 1 1 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5291
Local Reg. No. 718
Reg. Dist. No. 370

RECEIVED JAN 3 1968 Bureau of Vital

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 2032 Crystal Way

3. NAME OF DECEASED (Type or Print): a. (First) M. A. (Susan) b. (Middle) c. (Last) RANDALL

4. DATE OF DEATH (Month) (Day) (Year): December 30, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: March 27, 1872

9. AGE (In years last birthday): 95 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Grudy, Iowa

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Thomas McBirney — BIRTHPLACE: Ireland

14. MOTHER'S MAIDEN NAME: Anna Lelsa Tiedgen — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no ----

16. SOCIAL SECURITY NO.: 518-60-7017

17. INFORMANT'S OWN SIGNATURE: Lois E. Randall — ADDRESS: Boise, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic kidney disease — (??) several mos.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Acute entero-colitis — 3 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1950, *to* 12-30, 1967, *that I last saw the deceased alive on* 12-30, 1967, *and that death occurred at* 11:05 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner 364 (Degree or title): MD

23b. ADDRESS: 105 N. 8th St. Boise Idaho

23c. DATE SIGNED: 1/2/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Jan. 2, 1968

24c. NAME OF CEMETERY OR CREMATORY: Morris Hill Cemetery

24d. LOCATION (City, town, or county) (State): Boise Idaho

DATE REC'D BY LOCAL REG.: 1-3-68

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Lowell W. Summers

LICENSE NO.: E-509

FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 30 1969

JAN 3 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5292
Local Reg. No. 216
Reg. Dist. No. 371

RECEIVED JAN 17 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA 011 3-08
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): 8[illegible] DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): VETERANS ADMIN. CENTER 004

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: TWIN FALLS
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): TWIN FALLS 421
d. STREET ADDRESS (If rural, give location): RURAL ROUTE 1

3. NAME OF DECEASED (Type or Print)
a. (First): JOHN
b. (Middle): A
c. (Last): GRAY

4. DATE OF DEATH (Month) (Day) (Year): DEC. 30, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): SINGLE
8. DATE OF BIRTH: 12-29-93
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RANCHER 04
10b. KIND OF BUSINESS OR INDUSTRY: AGRICULTURE
11. BIRTHPLACE (State or foreign country): BUTTE, MONTANA
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: THOMAS M GRAY — BIRTHPLACE: TENNESSEE
14. MOTHER'S MAIDEN NAME: SUSAN ADAMS — BIRTHPLACE: OREGON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES — (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 530 20 1102
17. INFORMANT'S OWN SIGNATURE / ADDRESS: D.L. MOORE, Vet.Admin. Center, Boise, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

525X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cor pulmonale	2 yrs
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Pulmonary fibrosis	6 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Aortic dissection	48 hrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. ~~I hereby certify that I~~ The VA attended the deceased from Dec. 22, 1967, to Dec. 30, 1967, ~~that I last saw the deceased alive on 19~~ and that death occurred at 10:20A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Glenn Voyles 544 — GLENN Q VOYLES, M.D.
23b. ADDRESS: VET. ADMIN. CENTER, BOISE, IDA
23c. DATE SIGNED: 1-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12-31-67
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls, Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 12, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: G. W. Waters
LICENSE NO.: E-461

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cloverdale Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect, or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5293
Local Reg. No. 744
Reg. Dist. No. 370

BIRTH NO.

RECEIVED STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Ada 011 — JAN 17 1968 — Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise

c. LENGTH OF STAY (in this place): 0-00

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Alphonsus Hospital 003

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY: Ada

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011

d. STREET ADDRESS (If rural, give location): 4820 Roberts Road

3. NAME OF DECEASED (Type or Print): a. (First) Otis — b. (Middle) W. — c. (Last) Hon

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 31, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 17, 1900

9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hon Electric 32

10b. KIND OF BUSINESS OR INDUSTRY: Owner

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert Hon — BIRTHPLACE: Kansas

14. MOTHER'S MAIDEN NAME: Zella White — BIRTHPLACE: Virginia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-09-9344

17. INFORMANT'S OWN SIGNATURE: Edward Hubert Hon — ADDRESS: Boise

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5811 Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cancer's Cirrhosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: David Corbett MD (Degree or title) 557

23b. ADDRESS: Boise Idaho

23c. DATE SIGNED: 1/12/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: 1-2-68

24c. NAME OF CEMETERY OR CREMATORY: Mountain View

24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: Jan. 12, 1968

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAY 2 8 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5294
Local Reg. No. 9/9
Reg. Dist. No. 370

BIRTH NO.

RECEIVED JAN 3 1968
Bureau of Vital Sta

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 4½ months

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 001
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1909 North 15th Street

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boise Convalescent Home

3. NAME OF DECEASED (Type or Print): a. (First) WILLIS b. (Middle) E. c. (Last) KUKA

4. DATE OF DEATH (Month) (Day) (Year): December 31, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Sept. 20, 1913

9. AGE (In years last birthday): 54
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): janitor 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Synarep, Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank W. Kuka
BIRTHPLACE: Minnesota

14. MOTHER'S MAIDEN NAME: Mary Emma Isaacs
BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: 519-14-7747

17. INFORMANT'S OWN SIGNATURE: Jan Sullivan
ADDRESS: 211 S. 13 Boise, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute pulmonary edema — INTERVAL BETWEEN ONSET AND DEATH: 3 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Rheumatic Heart disease — 20+ yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* May 15, 1958, *to* Dec. 31, 1967, *that I last saw the deceased alive on* 12-23, 1967, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Paul F. Miner (Degree or title): M.D. 364

23b. ADDRESS: 105 N 8th St. Boise Idaho

23c. DATE SIGNED: 1/2/68

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Jan. 3, 1968

24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery

24d. LOCATION (City, town, or county) (State): Shoshone Idaho

DATE REC'D BY LOCAL REG.: 1-3-68

REGISTRAR'S SIGNATURE: Myrtle Palmer

25. EMBALMER: Fred E. Weber
LICENSE NO.: E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 3 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 8 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 15 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
JAN 1 1 1968
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5295
Local Reg. No. 736
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Ada 011
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 3 years 4 Mo. 1-03
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor 292

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. STREET ADDRESS (If rural, give location): 1721 Olympia Drive

3. NAME OF DECEASED (Type or Print)
a. (First): M Yles
b. (Middle): E
c. (Last): Barrowclough
BARROWCLOUGH

4. DATE OF DEATH (Month) (Day) (Year): Dec. 31, 1967

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Feb. 5, 1875
9. AGE (In years last birthday): 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Grocerman 25
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): England
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: No record — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Nova L. Hopton — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized Arteriosclerosis

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1967, *to* Dec 31, 1967, *that I last saw the deceased alive on* Dec 31, 1967, *and that death occurred at* 8:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 333
23b. ADDRESS: 808 Lelassia Dr
23c. DATE SIGNED: 1-6-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/4/68
24c. NAME OF CEMETERY OR CREMATORY: Syringa Garden
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Jan. 9, 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Conway Grant
LICENSE NO.: E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended February 8 1968

Certificate of Death

STATE OF IDAHO

State File No. 5296
Local Reg. No.
Reg. Dist. No. 370

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 01 Ada 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
c. LENGTH OF STAY (in this place) 18 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Restful Manor Nursing Home 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 01 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Boise
d. STREET ADDRESS (If rural, give location) 829 Warm Springs Ave.

3. NAME OF DECEASED (Type or Print)
a. (First) Cecile
b. (Middle) Dunn
c. (Last) White

4. DATE OF DEATH (Month) (Day) (Year) Dec. 31, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH July 30, 1892

9. AGE (In years last birthday) 75
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Curtis, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Chas. B. Compton
BIRTHPLACE New York

14. MOTHER'S MAIDEN NAME Frances M. Bowen
BIRTHPLACE Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No.
(If yes, give war or dates of service) ---

16. SOCIAL SECURITY NO. 564-30-0723A

17. INFORMANT'S OWN SIGNATURE Pat Northrup
ADDRESS Salt Lake

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3347

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebrovascular Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 19 67, *to* Dec 31, 19 67, *that I last saw the deceased alive on* Dec 31, 19 67, *and that death occurred at* 9:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE L. H. Mason, M.D. 333 (Degree or title)

23b. ADDRESS 808 LaCassia, Boise

23c. DATE SIGNED 1-8-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 1-4-68

24c. NAME OF CEMETERY OR CREMATORY Morris Hill

24d. LOCATION (City, town, or county) (State) Boise, Ada, Idaho

DATE REC'D BY LOCAL REG. Jan 8, 1968

REGISTRAR'S SIGNATURE Myrtle Palmer

25. EMBALMER Eldon T. Pearson

LICENSE NO. E-512

FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

2-5-68

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
FEB 5 1968
Bureau of Vital Statistics

State of .....
County of ..... } ss.

Certificate No. 67-5296

Date Filed .....

The undersigned does solemnly swear that certain facts on the certificate of death (Birth or Death)
for Cecila Dunn White (Name on Original Certificate) who died (Was Born or Died) on Dec. 31, 1967 (Date of Event)
in Boise, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the
true facts are shown by ..... (Bible Record, Insurance Policy, Etc.) prepared on ..... (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Birth Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Item 3a	Cecila	Cecile

Subscribed and sworn to before me this 8 day of February, 1968.

Harold L. Gilbert
Notary Public, residing at Eagle, Idaho
My commission expires Sept 28, 1968
(Seal)

Signed Idon T. Pearson,
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Ada } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 7th day of February, 1968.

Lorraine Gilbert
Notary Public, residing at Boise, Idaho
My commission expires Aug 7, 1968
(Seal)

Signed Donald R. Watson
(Signature of Any Credible Person)

2312 Pleasanton, Boise, Idaho
(Street Address, City, State)

FORM DH 60-155

Certificate of Death

STATE OF IDAHO

State File No. 5296
Local Reg. No. 737
Reg. Dist. No. 370

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, give RURAL and township): Boise
LENGTH OF STAY (in this place): 18 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Restful Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 829 Warm Springs Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Cecila b. (Middle) Dunn c. (Last) White

4. DATE OF DEATH: (Month) Dec. (Day) 31, (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 30, 1892
9. AGE (In years last birthday): 75 (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Curtis, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Chas B. Compton — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Frances M. Bowen — BIRTHPLACE: Michigan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 564-30-0723
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Salt Lake

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebrovascular Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1, 1967, *to* Dec 31, 1967, *that I last saw the deceased alive on* Dec 31, 1967, *and that death occurred at* 9:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 333 (Degree or title)
23b. ADDRESS: 808 Valencia. Boise.
23c. DATE SIGNED: 1-8-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-4-68
24c. NAME OF CEMETERY OR CREMATORY: Morris Hill
24d. LOCATION (City, town, or county) (State): Boise Ada Idaho

DATE REC'D BY LOCAL REG.: Jan. 8 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: Eldon T. Pearson — LICENSE NO.: E-512
FIRM NAME: Gibson Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

JAN 10 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 8 - 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 1 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 22 1967

State File No. 5297
Local Reg. No. 23
Reg. Dist. No. 300

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Adams 020 1-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural New Meadows
c. LENGTH OF STAY (in this place): 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): at home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural New Meadows 020
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) HOWARD b. (Middle) F c. (Last) DEAN

4. DATE OF DEATH (Month) (Day) (Year): December 6, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: November 24, 1892

9. AGE (In years last birthday): 75 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hospital Personnel

10b. KIND OF BUSINESS OR INDUSTRY: Dir., retired

11. BIRTHPLACE (State or foreign country): Los Angeles, California

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: no record — BIRTHPLACE: 30

14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 538-05-2964

17. INFORMANT'S OWN SIGNATURE: Julia H. Dean — ADDRESS: New Meadows, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Acute myocardial infarction — 30 min.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June —, 1963, *to* 12-6, 1967, *that I last saw the deceased alive on* 11-17, 1967, *and that death occurred at* 7:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wayne F. Allen M.D. 006

23b. ADDRESS: McCall, Idaho

23c. DATE SIGNED: 12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec 14, '67

24c. NAME OF CEMETERY OR CREMATORY: Mt. Jefferson Mem. Park

24d. LOCATION (City, town, or county) (State): Madras, Oregon

DATE REC'D BY LOCAL REG.:

REGISTRAR'S SIGNATURE:

25. EMBALMER: Burton E. Walker — LICENSE NO.: E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

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The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5298
Local Reg. No. 337
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

BIRTH NO.

DEC 26 1967
Bureau of Vital

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 750½ McKinley 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello 031
d. STREET ADDRESS (If rural, give location): 750½ McKinley

3. NAME OF DECEASED (Type or Print)
a. (First): ANGELA
b. (Middle): MARIE
c. (Last): AGGELER

4. DATE OF DEATH (Month) (Day) (Year): Nov. 16, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Sept. 1, 1967
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 2, Days 15 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Aggeler — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Sandra Mills — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: George Aggeler — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7710

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Sudden death, cause undetermined.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Pulmonary edema & hemorrhage, massive.
DUE TO (c): Congestion and hemorrhage, spleen

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/1/67, 19__, *to* 10/3/67, 19__, *that I last saw the deceased alive on* 10/3/67, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Richard E Oster MD 400
23b. ADDRESS: 246 No. 18th Poaatello,
23c. DATE SIGNED: 12/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 11-18-67
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cem.
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: DEC 21 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: John P. Gorma
LICENSE NO.: E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5298
Local Reg. No.
Reg. Dist. No.

BIRTH NO. DEC 26 1967

1. PLACE OF DEATH
a. COUNTY 030 Bannock (Bureau of Vital Statistics)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Swan Lake
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) son's home Swan Lake

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 030 Swan Lake
d. STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED (Type or Print) a. (First) Peter b. (Middle) 000 c. (Last) Sorenson

4. DATE OF DEATH (Month) (Day) (Year) Nov. 25, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Nov. 26, 1880

9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Dry farm & cattle

11. BIRTHPLACE (State or foreign country) Mejrup Ringhabierg Amt. Den.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jens Christian Sorensen — BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Christine Pederson — BIRTHPLACE Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-42-9645

17. INFORMANT'S OWN SIGNATURE Douglas Sorenson — ADDRESS Swan Lake, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 5, 1967 *to* Nov 25, 1967, *that I last saw the deceased alive on* 11-20, 1967, *and that death occurred at* 6:45 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE 070 (Degree or title)

23b. ADDRESS Downey Idaho

23c. DATE SIGNED 12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Nov. 29, 1967

24c. NAME OF CEMETERY OR CREMATORY Swan Lake Cemetery

24d. LOCATION (City, town, or county) (State) Swan Lake, Idaho

DATE REC'D BY LOCAL REG. Dec 14 67

REGISTRAR'S SIGNATURE Orissa Salvesen

25. EMBALMER O. Sherwin Webb — LICENSE NO. 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5300
Local Reg. No.
Reg. Dist. No.

RECEIVED DEC 26 1967 Bureau of

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 030 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
c. LENGTH OF STAY (in this place): 4 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Swan Lake 030
d. STREET ADDRESS (If rural, give location): Rural

3. NAME OF DECEASED (Type or Print): a. (First) Samuel b. (Middle) Leonidas c. (Last) Beckstead Sr.

4. DATE OF DEATH: (Month) Nov (Day) 29, (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
Male	white	Widowed 2	Feb 28, 1881	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farming 07
10b. KIND OF BUSINESS OR INDUSTRY: cattle - rancher
11. BIRTHPLACE (State or foreign country): Brigham City, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gordon Eli Beckstead — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Delina C. Smith — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-60-2959
17. INFORMANT'S OWN SIGNATURE: Mervie Beckstead — ADDRESS: Swan Lake, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 331.X Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Stroke

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis
DUE TO (c): Aged

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19 51, *to* 11-29, 19 67, *that I last saw the deceased alive on* 11-29, 19 67, *and that death occurred at* 6:20 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Early Burkholder 070 (Degree or title)
23b. ADDRESS: Downey Id
23c. DATE SIGNED: 12.11.67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 4, 1967	Swan Lake Cemetery	Swan Lake, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Orissa Salvesen	O. Sherwin Webb	316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5301
Local Reg. No. 329
Reg. Dist. No. 510

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

DEC 8 1967
Bureau of Vital Statistics

1. PLACE OF DEATH 031
a. COUNTY: Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF BIRTH (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 325 Filmore

3. NAME OF DECEASED (Type or Print)
a. (First): LEO
b. (Middle): L.
c. (Last): PACKER

4. DATE OF DEATH (Month) (Day) (Year): Nov. 29, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 30, 1902
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Dept.
10b. KIND OF BUSINESS OR INDUSTRY: I.S.U. 06
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Leonidas Packer — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Martha Nelson — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: 519 14 1316
17. INFORMANT'S OWN SIGNATURE: Ina M. Packer — ADDRESS: Pocatello

18. CAUSE OF DEATH 465X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary embolus — INTERVAL BETWEEN ONSET AND DEATH: 1 Year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 18 Nov, 1967, *to* 29 Nov, 1967, *that I last saw the deceased alive on* 29 Nov, 1967, *and that death occurred at* 11 P *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 113 (Degree or title): MD
23b. ADDRESS: Pocatello Ida
23c. DATE SIGNED: Dec 4 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 2, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Bannock, Idaho

DATE REC'D BY LOCAL REG.: DEC 5 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 8 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 21 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5302
Local Reg. No. 332
Reg. Dist. No. 510

Certificate of Death

RECEIVED

BIRTH NO.

STATE OF IDAHO

DEC 18 1967

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 031
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 446 North 6th Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): ELSIE
b. (Middle):
c. (Last): PLUNKETT

4. DATE OF DEATH (Month) (Day) (Year): Dec. 2, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 19, 1909
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Vernon County, Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Henry — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Effie — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): X XXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Earl H. Plunkett — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

150X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinoma of esophagus — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 8, 1967, *to* Dec 2, 1967, *that I last saw the deceased alive on* Dec 1, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 113 MD
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: Dec 9 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: DEC 12 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. FUNERAL DIRECTOR: F. B. Ashley — Manning Chapel — ADDRESS: 510 North 12th

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a~~ person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of F B Ashby Lic. No. E418 at Pocatello on Dec 2, 67

ADDITIONAL REMARKS by Physician

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5303
Local Reg. No. 333
Reg. Dist. No. 510

BIRTH NO.

RECEIVED DEC 18 1967 Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 03
b. COUNTY: Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 537 South 5th Avenue

3. NAME OF DECEASED (Type or Print): a. (First) LILA; b. (Middle) H.; c. (Last) WOOLARD

4. DATE OF DEATH: (Month) December (Day) 4 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: September 12, 1883

9. AGE (In years last birthday): 84 | If under 1 year: Months / Days | If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Smithfield Utah

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Thomas H. Hargraves — BIRTHPLACE: Wales

14. MOTHER'S MAIDEN NAME: Elizabeth Harris — BIRTHPLACE: Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Fay W. Merrill — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardio-Vascular — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pneumonia, Cardiac Failure — 1-3 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* Dec. 4, 19 67, *that I last saw the deceased alive on* Dec. 4, 1967, *and that death occurred at* 12:50p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Dan C. Miller M.D.

23b. ADDRESS: Pocatello Idaho

23c. DATE SIGNED: Dec. 7, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 7, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: DEC 1 1 1967

REGISTRAR'S SIGNATURE: Gloria Doate

25. EMBALMER: Jack Henderson — LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 18 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5304
Local Reg. No. 334
Reg. Dist. No. 511

BIRTH NO.

RECEIVED DEC 18 1967

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCammon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES; b. (Middle) ABRAM; c. (Last) ROMRIELL

4. DATE OF DEATH: (Month) Dec. (Day) 4, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: June 30, 1868

9. AGE (In years last birthday): 99 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Five Points, Ogden, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles A. Romriell — BIRTHPLACE: France

14. MOTHER'S MAIDEN NAME: Mary Marley — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Charles Romriell — ADDRESS:

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Advanced age and senility.

DUE TO (c) Deafness. Decubitus ulcers, both heels. Senile dermatitis.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July 17, 1967, *to* December 4, 1967, *that I last saw the deceased alive on* Dec. 4, 1967, *and that death occurred at* 3:10p m., *from the causes and on the date stated above.*

23a. SIGNATURE AND 56 (Degree or title): ARCH WIGLE, M.D.

23b. ADDRESS: 1605 North Arthur, Pocatello, Idaho

23c. DATE SIGNED: 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 8, 1967

24c. NAME OF CEMETERY OR CREMATORY: McCammon Cemetery

24d. LOCATION (City, town, or county) (State): McCammon, Bannock, Idaho

DATE REC'D BY LOCAL REG.: DEC 14 1967

REGISTRAR'S SIGNATURE: Gloria Spita

25. FUNERAL DIRECTOR: Manning Chapel — ADDRESS: 510 North 12th

Federal Security Agency
United States Public Health Service

Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 20 1988

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of F. B. Ashby Lic. No E448 at Pocatello on Dec 4, 67

ADDITIONAL REMARKS by Physician .....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5305
Local Reg. No. 338
Reg. Dist. No. 510

BIRTH NO.

DEC 26 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 03/ Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 03/ Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
d. STREET ADDRESS (If rural, give location) 018

3. NAME OF DECEASED (Type or Print) a. (First) SCOTT b. (Middle) c. (Last) WHITE

4. DATE OF DEATH (Month) (Day) (Year) Dec. 6, 1967

5. SEX Male
6. COLOR OR RACE Negro
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)
8. DATE OF BIRTH Feb. 29, 1910
9. AGE (In years last birthday) 57 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Brooks County, Georgia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Isaac White BIRTHPLACE
14. MOTHER'S MAIDEN NAME Sarah Phelps BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown (If yes, give war or dates of service) xxxx
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 161X Carcinoma of Larynx

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-1, 1967 *to* 12-6, 1967 *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE 158 (Degree or title) MD,
23b. ADDRESS 322 Jefferson
23c. DATE SIGNED 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 8, 1967
24c. NAME OF CEMETERY OR CREMATORY Mountainview Cemetery
24d. LOCATION (City, town, or county) (State) Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REGISTRAR DEC 15 1967
REGISTRAR'S SIGNATURE
25. FUNERAL DIRECTOR Manning Chapel ADDRESS 510 North 12th

Federal Security Agency
United States Public Health Service
Form DPH-43021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of F. B. Ashby Lic. No. E418 at Pocatello on Dec 6, 67

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 1 8 1967

Certificate of Death

STATE OF IDAHO

State File No. 5306
Local Reg. No. 335
Reg. Dist. No. 5 / 0

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Nursing Home 299

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 506 South Lincoln

3. NAME OF DECEASED (Type or Print)
a. (First): HYRUM
b. (Middle): M.
c. (Last): COOPER

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 6, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: July 26, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Richmond, Utah
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Cooper — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Sarah Whitehead — BIRTHPLACE: England
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): xxxx
16. SOCIAL SECURITY NO.: 518 14 1957A
17. INFORMANT'S OWN SIGNATURE: Donald L. Cooper — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Cardio - Vascular — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Disease, unk. Cardio - renal failure

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Prostate, Limit Pathological fracture Lt. hip — 4 months

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* 12-6-, 1967, *that I last saw the deceased alive on* 12-6-67 19__, *and that death occurred at* 4P m. *from the causes and on the date stated above.*

23a. SIGNATURE: Harold C. Miller, M.D. 362 (Degree or title)
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 12-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: DEC 14 1967
REGISTRAR'S SIGNATURE: Gloria Norris
25. FUNERAL DIRECTOR: Manning Chapel — ADDRESS: 510 North 12th

Federal Security Agency
United States Public Health Service

Form DPH-48021

DUTIES:

DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of J B Ashby Lic. No E418 at Pocatello on Dec 6, 67

ADDITIONAL REMARKS by Physician

State File No. 5307
Local Reg. No. 350
Reg. Dist. No. 510

Certificate of Death

RECEIVED
JAN 5 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Bannock Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First): LORA
b. (Middle): ANN
c. (Last): CLEVELAND

4. DATE OF DEATH (Month) (Day) (Year): December 7 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: April 20, 1871
9. AGE (In years last birthday): 96 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: *****
11. BIRTHPLACE (State or foreign country): Unidella New York
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Floyd Thayer — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Rozella Fox — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: *****
17. INFORMANT'S OWN SIGNATURE: Ida Schoolcraft — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5021

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Senility — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Chronic Bronchitis — 5 years

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello Bannock Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1965, 19__, *to* Dec. 7, 19 67, *that I last saw the deceased alive on* [redacted] 19 67, *and that death occurred at* 5:40 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): B. Howard M.D. 248
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Dec. 9, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 9, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: JAN 3 1968
REGISTRAR'S SIGNATURE: Glorce Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify [redacted] of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5308
Local Reg. No. 336
Reg. Dist. No. 510

Certificate of Death

RECEIVED DEC 18 1967

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 333 East Center Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannnck
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 333 East Center Street

3. NAME OF DECEASED (Type or Print)
a. (First): JULIA
b. (Middle): M.
c. (Last): MARKS

4. DATE OF DEATH (Month) (Day) (Year): December 8 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 17, 1907
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: At Home
11. BIRTHPLACE (State or foreign country): Denver Colorado
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Steve Mitchell — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Mary Mitchell — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: *****
17. INFORMANT'S OWN SIGNATURE: McGill Marks — ADDRESS: Pocatello, Idah

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from 19 to 19, that I last saw the deceased alive on* December 8 1967, *and that death occurred at* 4:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE: Burton H John 583 (Degree or title) 4
23b. ADDRESS: Bannock County Coroner, Pocatello, Ida
23c. DATE SIGNED: Dec. 11, '67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Dec. 12, 1967
24c. NAME OF CEMETERY OR CREMATORY: St. John's Funeral Home
24d. LOCATION (City, town, or county): Portland (State): Oregon

DATE REC'D BY LOCAL REG.: DEC 12 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 5 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 4 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

REC

Certificate of Death

STATE OF IDAHO

State File No. 5309
Local Reg. No. 339
Reg. Dist. No. 5-10

BIRTH NO.

DEC 26 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 018 Bannock Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 03 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 920 West Clark Street

3. NAME OF DECEASED (Type or Print): a. (First) PAULINE; b. (Middle) T.; c. (Last) HERRIDGE

4. DATE OF DEATH: (Month) December (Day) 8 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: August 27, 1915

9. AGE (In years last birthday): 52 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waitress 06

10b. KIND OF BUSINESS OR INDUSTRY: Restrauant

11. BIRTHPLACE (State or foreign country): Pocatello Idaho

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Grant Tackley — BIRTHPLACE: New York

14. MOTHER'S MAIDEN NAME: Bertha Bromm — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Jack L. Herridge — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1250

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcinoma of Both Ovaries — INTERVAL BETWEEN ONSET AND DEATH: 18 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Nov. 9, 1966

19b. MAJOR FINDINGS OF OPERATION: Extensive Bilateral Adenocarcinoma Ovarian

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* Dec. 8, 19 67, *that I last saw the deceased alive on* Dec. 8, 19 67, *and that death occurred at* 7:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE 396 (Degree or title): [signature]

23b. ADDRESS: Pocatello Idaho

23c. DATE SIGNED: Dec. 11, 196 7

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatello Idaho

DATE REC'D BY LOCAL REG.: DEC 1 0 1967

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Jack Henderson — LICENSE NO.: E -349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under [illegible] inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 1967

JAN 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in Ov... be answered as completely as possible. State answers as unknown only after a careful investigation. Use ... typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 17 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5310
Local Reg. No. 372
Reg. Dist. No. 5 11

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 030
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lava Hot Springs
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Valley View Nursing Home 021

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin 211
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Emma b. (Middle) Dalilah c. (Last) Coburn Hansen

4. DATE OF DEATH (Month) (Day) (Year) December 9, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH June 19, 1885
9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own home
11. BIRTHPLACE (State or foreign country) Mink Creek, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Peter Egley BIRTHPLACE
14. MOTHER'S MAIDEN NAME Elisabeth Burkhalter BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Weldon P. Hansen ADDRESS Preston, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis
DUE TO (c) Arteriosclerotic Heart Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 7-22, 1966, to Dec 9, 1967, that I last saw the deceased alive on 12-24, 1967, and that death occurred at 9:15 m., from the causes and on the date stated above.

23a. SIGNATURE Leo G. Burkhalter M.D. 070 (Degree or title)
23b. ADDRESS Downey, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Lava Hot Springs Cemetery
24d. LOCATION (City, town, or county) (State) Lava Hot Springs, Idaho

DATE REC'D BY LOCAL REG. Jan-12-68
REGISTRAR'S SIGNATURE Orissa Salvesen
25. EMBALMER O. Sherwin Webb
LICENSE NO. 316

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: Webb Funeral Home

DUTIES:

JAN 18 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5311
Local Reg. No. 343
Reg. Dist. No. 511

BIRTH NO.

1. PLACE OF DEATH — JAN 2 1968
a. COUNTY: Bannock 03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony's Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 011
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location): Route 3

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LEO	KENNETH	OLESON	December 9 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
male	white	married	January 9, 1892	75		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Big Band, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oliver Oleson — BIRTHPLACE: Whitewater, Wisc.
14. MOTHER'S MAIDEN NAME: Sarah Jane Meech — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-40-7630
17. INFORMANT'S OWN SIGNATURE: Hatasu Oleson — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Acute myocardial infarct	4 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic H.D.	3 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. CITY, TOWN, OR TOWNSHIP (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1952, 19__, *to* Dec 9, 1967, *that I last saw the deceased alive on* Dec 9, 1967, *and that death occurred at* 2 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 248 M.D.	Pocatello, Idaho	12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 13, 1967	Grove City Cemetery	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 28 1967	[signature]	[signature]	E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 2 1968

JUL 2 1976

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to obtain the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5312
Local Reg. No. 340
Reg. Dist. No. 511

BIRTH NO.

DEC 26 1967 STATE OF IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 030 Bannock
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 030 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Fort Hall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) TITUS
b. (Middle) ROBERT
c. (Last) WILDCAT

4. DATE OF DEATH (Month) (Day) (Year) Dec. 10, 1967

5. SEX Male

6. COLOR OR RACE Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married

8. DATE OF BIRTH May 24, 1965

9. AGE (In years last birthday) 2
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 09

10b. KIND OF BUSINESS OR INDUSTRY xxxx

11. BIRTHPLACE (State or foreign country) Pocatello, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Farrell Robert Wildcat
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Isabell Pohipe
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) xxxxx

16. SOCIAL SECURITY NO. xxxx

17. INFORMANT'S OWN SIGNATURE Farrell R Wildcat
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 517X Epiglottitis Causing

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Suffocation

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Thomas Reuss (Degree or title) 584 MD,
23b. ADDRESS Ft Hall Idaho
23c. DATE SIGNED 12/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Bannock Creek Cemetery,
24d. LOCATION (City, town, or county) Fort Hall, Idaho (State)

DATE REC'D BY LOCAL REG. DEC 19 1967
REGISTRAR'S SIGNATURE Gloria Dopita

25. FUNERAL DIRECTOR Manning Chapel
ADDRESS 510 North 12th

Federal Security Agency
United States Public Health Service
Form DPH-48021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DEC 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of F.B. Ashby Lic. No. E418 at Pocatello on Dec 10, 67

ADDITIONAL REMARKS by Physician

State File No. 5313
Local Reg. No. 341
Reg. Dist. No. 510

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 26 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 331 So. Grant 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 331 So. Grant

3. NAME OF DECEASED (Type or Print)
a. (First): Elizabeth
b. (Middle): (Buff)
c. (Last): Denio

4. DATE OF DEATH (Month) (Day) (Year): Dec. 11, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Jan. 10, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: J. W. Jackson — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Ivey Williams — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Don C. Denio — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Ht. Disease — INTERVAL BETWEEN ONSET AND DEATH: 6 weeks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello Bannock Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1959, *to* Dec 11, 1967, *that I last saw the deceased alive on* Nov 30 1967, *and that death occurred at* 9 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R P Howard MD 248
23b. ADDRESS: Pocatello Ida
23c. DATE SIGNED: 12-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-14-67
24c. NAME OF CEMETERY OR CREMATORY: Soda Springs Cem.
24d. LOCATION (City, town, or county) (State): Soda Springs, Idaho

DATE REC'D BY LOCAL REG.: DEC 18 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: John P. Gorman
LICENSE NO.: E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED
DEC 26 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5314
Local Reg. No. 342
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 723 North Arthur

3. NAME OF DECEASED (Type or Print): a. (First) LUCY b. (Middle) PEARL c. (Last) BARNES

4. DATE OF DEATH: (Month) Dec. (Day) 12, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married

8. DATE OF BIRTH: May 28, 1895

9. AGE (In years last birthday): 72
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Hillman Barnes
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Bethia Wilkins
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): XXXX

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Robert A. Barnes
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

1792

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic carcinoma.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Primary site intraabdom.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 5 Months

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug 4, 1967, *to* Dec 12, 1967, *that I last saw the deceased alive on* Dec 12, 1967, *and that death occurred at* 9:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Michael Wonnum 774 (Degree or title) MD,

23b. ADDRESS: Kasiska Bldg Pocat

23c. DATE SIGNED: 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 16, 1967

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls Bonneville, Ida.

DATE REC'D BY LOCAL REG.: DEC 19 1967

REGISTRAR'S SIGNATURE: Glenn Davis

25. FUNERAL DIRECTOR: Manning Chapel
ADDRESS: 510 North 12th

Federal Security Agency
United States Public Health Service

Form DPH-48021

DEC 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

State File No. 5315
Local Reg. No. 351
Reg. Dist. No. 510

BIRTH NO.

RECEIVED STATE OF IDAHO

JAN 5 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Rest Home 294

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1071 Renee Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): GEORGE
b. (Middle):
c. (Last): THOMPSON

4. DATE OF DEATH (Month) (Day) (Year): Dec. 14, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: April 7, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carman 09
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): New York, New York
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Angelo Thompson — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Mary Tidozo — BIRTHPLACE: New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.: 528 10 0981
17. INFORMANT'S OWN SIGNATURE: Aaron L Davidson — ADDRESS: Pocatello, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 1/2 1/2 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Diabetes mellitus — Unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* August, 1965, *to* Dec 14, 1967, *that I last saw the deceased alive on* Nov 21, 1967, *and that death occurred at* 4:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L Davidson MD 009
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: Dec 20 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: JAN 1 1968
REGISTRAR'S SIGNATURE: Gloria Dopita
25. FUNERAL DIRECTOR: [signature] — ADDRESS: Manning Chapel 510 North 12th

Federal Security Agency
United States Public Health Service
Form DPH-48021

DUTIES: JAN. 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of F. B. Ashby Lic. No. E418 at Pocatello on Dec 14, 67

ADDITIONAL REMARKS by Physician

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 2 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5316
Local Reg. No. 346
Reg. Dist. No. 2-11

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pocatello
c. LENGTH OF STAY (in this place) 17days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bannock Mem. Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Bannock County
d. STREET ADDRESS (If rural, give location) Rio Vista Road

3. NAME OF DECEASED (Type or Print) a. (First) Edith b. (Middle) c. (Last) Pederson

4. DATE OF DEATH (Month) (Day) (Year) Dec. 15, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH March 7,1890

9. AGE (In years last birthday) 77
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Wisconsin

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Linton McNeel
BIRTHPLACE England

14. MOTHER'S MAIDEN NAME Nellie Butler
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Alfred L. Pederson
ADDRESS Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 6000 Chronic Pyelonephritis
INTERVAL BETWEEN ONSET AND DEATH 40yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug 4, 1967, to Dec 15, 1967, that I last saw the deceased alive on Dec 14, 1967, and that death occurred at 1:40 m., from the causes and on the date stated above.

23a. SIGNATURE Richard E Ostler 400 (Degree or title)

23b. ADDRESS 246 N. 18th Pocatello Idaho

23c. DATE SIGNED 12/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-18-1967

24c. NAME OF CEMETERY OR CREMATORY Mount Moriah Cem

24d. LOCATION (City, town, or county) Pocatello, Idaho (State)

DATE REC'D BY LOCAL REG. DEC 29 1967

REGISTRAR'S SIGNATURE Gloria Oppeta

25. EMBALMER John P. Downard

LICENSE NO. E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 15 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5317
Local Reg. No. 344
Reg. Dist. No. 511

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JAN 2 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031 3-14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Blackfoot
d. STREET ADDRESS (If rural, give location): Rt. #3 (Riverton Rd.)

3. NAME OF DECEASED (Type or Print)
a. (First): Lilly
b. (Middle):
c. (Last): Lindsay

4. DATE OF DEATH (Month) (Day) (Year): Dec. 18, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Sept. 27, 1921
9. AGE (In years last birthday): 46 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife - beauty op.
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Albert Hofer — BIRTHPLACE: Switzerland
14. MOTHER'S MAIDEN NAME: Magdalena Hunzinger — BIRTHPLACE: Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-14-9839
17. INFORMANT'S OWN SIGNATURE: Orris R Lindsay — ADDRESS: Rt.#3, Blackfoot

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cancer of Cervix — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1-7, 1966, *to* 12-17, 1967, *that I last saw the deceased alive on* 12-17, 1967, *and that death occurred at* 3:42 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: D L Miyhr 565 (Degree or title): M.D.
23b. ADDRESS: E. Center St. Pocatello, Idaho
23c. DATE SIGNED: 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-21-67
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot, Bingham, Idaho

DATE REC'D BY LOCAL REG.: DEC 28 1967
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Howard Packham
LICENSE NO.: E-338

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Howard Packham Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

APR 9 1968

SEP 21 1994

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to sign the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5318
Local Reg. No. 369
Reg. Dist. No. 511

RECEIVED JAN 15 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 030 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Downey
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Marsh Valley Hospital 020

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 030
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCammon
d. STREET ADDRESS (If rural, give location): - -

3. NAME OF DECEASED (Type or Print)
a. (First): ANNIE
b. (Middle):
c. (Last): PIRRIE

4. DATE OF DEATH (Month) (Day) (Year): Dec. 19, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 22, 1878
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Scotland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alexander Gammie — BIRTHPLACE: Scotland
14. MOTHER'S MAIDEN NAME: Eliza Robertson — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: A. H. Wagner — ADDRESS: McCammon, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Artery Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c): Generalized

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March, 1955, *to* Dec 19, 1967, *that I last saw the deceased alive on* Dec 19, 1967, *and that death occurred at* 5 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 070 M.D.
23b. ADDRESS: Downey Idaho
23c. DATE SIGNED: Jan. 11, 1968

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY: Harkness Cem.
24d. LOCATION (City, town, or county) (State): McCammon, Idaho

DATE REC'D BY LOCAL REG.: JAN 12 1968
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: John P. Gronna
LICENSE NO.: E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 17 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 5 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5319
Local Reg. No. 352
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 918

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 722 South Fourth Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JOSEPH	ALMA	MARLEY	Dec. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	March 31, 1885	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheriff 08	Law Enforcement	Robin, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Marley	Wales	Mary Deborah Stinger	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	XXXX		Annie M. Marley	Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: App 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — sev yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
No		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 20, 1967, *to* Dec. 20, 1967, *that I last saw the deceased alive on* Dec. 20, 1967, *and that death occurred at* 11:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J.E. Comstock, M.D.	P. O. Box 852	12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 23, 1967	Restlawn Mem. Gardens	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
JAN 2 1968	Gloria Dopita	Manning Chapel	510 North 12th

Social Security No.
United States Public Health Service

Form DPH-48021

JAN 8 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of F B Ashby Lic. No. E414 at Pocatello on Dec 20, 67

ADDITIONAL REMARKS by Physician

Certificate of Death

STATE OF IDAHO

State File No. 5320
Local Reg. No. 345
Reg. Dist. No. 510

RECEIVED
JAN 2 1968

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Pocatello
Length of Stay (In this place): Duration Unit: Duration Amount:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 340 So. Arthur Apt. 101

3. NAME OF DECEASED (Type or Print): a. (First) PAULINE b. (Middle) c. (Last) TOOMBS

4. DATE OF DEATH (Month) (Day) (Year): Dec. 21, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married

8. DATE OF BIRTH: June 8, 1902

9. AGE (In years last birthday): 65
If under 1 year: Months / Days
If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY: School District

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John A. Toombs
BIRTHPLACE: Iowa

14. MOTHER'S MAIDEN NAME: Katherine Ann O'Brien
BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-34-1491

17. INFORMANT'S OWN SIGNATURE: Katherine Toombs
ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4168

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Rheumatic Heart Disease, Cardiac failure, Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 2 months.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Mitral Heart Cardiac arrest.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November, 1967 *to* 12-21-67, 19___, *that I last saw the deceased alive on* 12-21-, 1967, *and that death occurred at* 3:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: David C. Miller, M.D. 362 (Degree or title)

23b. ADDRESS: Pocatello Idaho

23c. DATE SIGNED: 12-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-23-67

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem.

24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: DEC 2 0 1967

REGISTRAR'S SIGNATURE: Gloria Depta

25. EMBALMER: John P. Downard

LICENSE NO.: E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

JAN 2 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5321
Local Reg. No. 353
Reg. Dist. No. 510

RECEIVED JAN 5 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1025 East Sublette Street

3. NAME OF DECEASED (Type or Print)
a. (First): FREEMAN
b. (Middle): LOREN
c. (Last): THOMAS

4. DATE OF DEATH (Month) (Day) (Year): December 22 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 15, 1907
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: Ramirez Enterprises
11. BIRTHPLACE (State or foreign country): Turner Idaho
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Samuel George Thomas — BIRTHPLACE: Harrisville, Utah
14. MOTHER'S MAIDEN NAME: Mary Alfreda Hancock — BIRTHPLACE: Payson, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****
16. SOCIAL SECURITY NO.: 519-07-3856
17. INFORMANT'S OWN SIGNATURE: Mrs. M. Myers — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

163X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Lung. — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Biopsy of chest lesion
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec-10, 1967, *to* Dec. 22, 1967, *that I last saw the deceased alive on* Dec. 22, 1967, *and that death occurred at* 7:15p *m., from the causes and on the date stated above.*

23a. SIGNATURE: David C. Miller, M.D. 362 (Degree or title)
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: Dec. 26, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 27, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Gardens
24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: JAN 3 1968
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: Jack Henderson
LICENSE NO.: E - 349

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HENDERSON FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 8 1968

MAY 25 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5322
Local Reg. No. 358
Reg. Dist. No. 510

RECEIVED JAN 8 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1032 South 4th

3. NAME OF DECEASED (Type or Print)
a. (First): MARVIN
b. (Middle): LEE
c. (Last): CORBRIDGE

4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 10, 1906
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Master Sergeant 05
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Army
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph Lee Corbridge — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Elvira Byington — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): Years
16. SOCIAL SECURITY NO.: 529 03 9407HA
17. INFORMANT'S OWN SIGNATURE: Pearl Barta — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Diabetic acidosis — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Diabetes mellitus
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 7, 1967, *to* Dec. 23, 1967, *that I last saw the deceased alive on* Dec. 23, 1967, *and that death occurred at* 11:32 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 077 (Degree or title): L.S.Call, MD
23b. ADDRESS: P. O. Box 852
23c. DATE SIGNED: 1-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Dec.26,1967
24c. NAME OF CEMETERY OR CREMATORY: Univ.of Utah College of Medicine
24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: JAN 5 1968
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature] — LICENSE NO. E418

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Manning Funeral Chapel

JAN 8 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 13 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 27 1969

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5323
Local Reg. No. 357
Reg. Dist. No. 511

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 8 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 030 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Inkom
d. STREET ADDRESS (If rural, give location): Route #2 Box 44

3. NAME OF DECEASED (Type or Print)
a. (First): MAUDE
b. (Middle):
c. (Last): RHOADES

4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1967

5. SEX: FEMale
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: July 12, 1877
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Holdredge, Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Richard Rowley — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Evelyn — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXXX
16. SOCIAL SECURITY NO.: XXXX
17. INFORMANT'S OWN SIGNATURE: Ethel Barron — ADDRESS: Inkom, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arterio sclerotic Cardio-Vascular disease with acute cardiac arrest

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: yes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1956, 19__, *to* 12-23, 1967, *that I last saw the deceased alive on* 12-23, 1967, *and that death occurred at* 6:31 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David C. Miller, M.D. 5362
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 1-2-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Inkom Cemetery
24d. LOCATION (City, town, or county) (State): Inkom, Bannock, Idaho

DATE REC'D BY LOCAL REG.: JAN 5 1968
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5324
Local Reg. No. 364
Reg. Dist. No. 510

BIRTH NO.

RECEIVED
JAN 15 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
DURATION OF STAY (in this place): DOD
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 356 Moreland

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LULA		HALL	Dec. 24, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If UNDER 1 YEAR Months	Days	If UNDER 24 HRS. Hours	Min.
Female	White	Widowed	June 22, 1899	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Own Home	Louisa, Kentucky	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joe D. Hatifield	Kentucky	Sarah Akers	Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	X XXX		Lola Jackson Hall	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic abdominal carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct 25, 1967, *to* Dec 24, 1967, *that I last saw the deceased alive on* Dec 24, 1967, *and that death occurred at* 7:35 p m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
[signature] MD (Degree or title)	Pocatello, Idaho	Jan 4 68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 28, 1967	Mountainview Cemetery	Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JAN 9 1968	Gloria Dopita	[signature]	E418

FIRM NAME: Manning Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5325
Local Reg. No. 349
Reg. Dist. No. 510

RECEIVED
JAN 2 1968
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 318 Hurley Drive

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): J.
c. (Last): HILL

4. DATE OF DEATH (Month) (Day) (Year): Dec. 24, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 12, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Salem, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Hill — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Mary Ann Williamson — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XX
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: John E. Hill — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertensive Vascular Disease — yrs.
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Fractured Lt. hip.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* 12-24-, 1967, *that I last saw the deceased alive on* 12-24-, 1967, *and that death occurred at* 6P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald C. Miller, MD 362
23b. ADDRESS: Pocatello, Idaho
23c. DATE SIGNED: 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 27, 1967
24c. NAME OF CEMETERY OR CREMATORY: Restlawn Mem. Gardens
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG.: DEC 29 1967
REGISTRAR'S SIGNATURE: Florence Dopelo
25. EMBALMER: [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 3 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 21 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5326
Local Reg. No. 354
Reg. Dist. No. 511

Certificate of Death

RECEIVED
JAN 5 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): Route #2 North

3. NAME OF DECEASED (Type or Print)
a. (First): DEAN
b. (Middle):
c. (Last): WILLIAMS

4. DATE OF DEATH (Month) (Day) (Year): Dec. 25, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 7, 1908
9. AGE (In years last birthday): 59 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Maintenance Mechanic
10b. KIND OF BUSINESS OR INDUSTRY: Simplots
11. BIRTHPLACE (State or foreign country): Driggs, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James M. Williams — BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: Miranda Grisson — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): XXXX
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Izetta M. Williams — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8254

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Massive Brain damage — INTERVAL BETWEEN ONSET AND DEATH: 12 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): North of Pocatello 26
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Pocatello 13 Bannock 031 Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12-24-67 11:30a.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Automobile accident

22. *I hereby certify that I attended the deceased from* 12-24-67, *19*___, *to* 12-25-67, *19*___, *that I last saw the deceased alive on* 12-25-67, *19*___, *and that death occurred at* 1:00 p *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Edward B. Shaw, M.D. 467
23b. ADDRESS: 246 N. 18th Ave. Pocatello, Ida.
23c. DATE SIGNED: 12-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY: Victor Cemetery
24d. LOCATION (City, town, or county) (State): Victor, Idaho

DATE REC'D BY LOCAL REG.: JAN 2 1968
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: F. B. Ashby
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5327
Local Reg. No. 347
Reg. Dist. No. 510

RECEIVED
JAN 2 1968
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 1-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hosp. 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 240 W. Center St.

3. NAME OF DECEASED (Type or Print)
a. (First): LOUIS
b. (Middle): W
c. (Last): FOLKNER

4. DATE OF DEATH (Month) (Day) (Year): Dec. 25 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Dec. 28, 1899
9. AGE (In years last birthday): 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Signal Dept. 09
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Hadden, Kansas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Folkner — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Hattie Gray — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Dennis Folkner, Pocatello, Idaho — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease, auricular fibrillation, myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Arteriosclerosis — yes

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967, 19__, *to* 12-25, 1967, *that I last saw the deceased alive on* 12-24, 1967, *and that death occurred at* 7 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Daniel C. Miller, M.D. 362
23b. ADDRESS: Pocatello Idaho
23c. DATE SIGNED: 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 28 Dec 1967
24c. NAME OF CEMETERY OR CREMATORY: Mountainview
24d. LOCATION (City, town, or county): Pocatello (State): Idaho

DATE REC'D BY LOCAL REG.: DEC 29 1967
REGISTRAR'S SIGNATURE: Gloria Dopeta
25. EMBALMER: George W. Knopf
LICENSE NO.: 409

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 6 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 23 1975

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5328
Local Reg. No. 348
Reg. Dist. No. 510

RECEIVED JAN 2 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hosp 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1533 East Oak

3. NAME OF DECEASED (Type or Print)
a. (First): RANDY
b. (Middle): RAYMOND
c. (Last): STEINMAN

4. DATE OF DEATH (Month) (Day) (Year): Dec. 26, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Oct. 9, 1953
9. AGE (In years last birthday): 14 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Junior High School
11. BIRTHPLACE (State or foreign country): Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joesph R. Steinman — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Audrey Joffrion — BIRTHPLACE: Louisiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Joseph R Steinman — ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2001

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Extensive lymphosarcoma

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1967, *to* Dec 26, 1967, *that I last saw the deceased alive on* Dec 26, 1967, *and that death occurred at* 1:40 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 107 (Degree or title)
23b. ADDRESS: 107 N 5th Pocatello
23c. DATE SIGNED: Dec. 27, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-29-67
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem.
24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REG.: DEC 20 1967
REGISTRAR'S SIGNATURE: Gloria Dopeta
25. EMBALMER: John P. Gorman — LICENSE NO. E-292

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Downard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5329
Local Reg. No. 359
Reg. Dist. No. 510

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 031 Bannock

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: 031 Bannock

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello

d. STREET ADDRESS (If rural, give location): 48 Orchard Drive

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ROZILLA		TOLMAN	Dec. 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	July 18, 1884	83				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Willard, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Alma Dalton	Unknown	Elizabeth Jane Cook	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	xxxxxx	519 01 9660		

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: sev. yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* _____, 1957, *to* Dec. 26, 1967, *that I last saw the deceased alive on* Dec. 26, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
L.S. Call	MD	P. O. Box 852	1-4-68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 30, 1967	Lava Hot Springs Cem.	Lava Hot Springs, Bannock, Id

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
JAN 5 1968	Gloria Watts		E418

FIRM NAME: Manning Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 31 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5330
Local Reg. No. 355
Reg. Dist. No. 510

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031 — JAN 5 1968 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello — Bureau of Vital Statistics — c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Anthony Community Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: 031 Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatelle
d. STREET ADDRESS (If rural, give location): 354 Yellowstone Avenue

3. NAME OF DECEASED (Type or Print): a. (First) LEOTA — b. (Middle) — c. (Last) JONES

4. DATE OF DEATH: (Month) (Day) (Year): December 27 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: August 27, 1891

9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Springdale Akransas

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Henry Bryant — BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Florence Ownbey — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): *****

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Edna Jones — ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

331 X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 16 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec. 26, 1967, *to* Dec. 27, 1967, *that I last saw the deceased alive on* Dec. 27, 1967, *and that death occurred at* 8:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: J H Anderson M D 009 (Degree or title)

23b. ADDRESS: Pocatello, Idaho

23c. DATE SIGNED: Dec. 30, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 30, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery

24d. LOCATION (City, town, or county) (State): Pocatelle Idaho

DATE REC'D BY LOCAL REG.: JAN 3 1968

REGISTRAR'S SIGNATURE: Gloria Dopita

25. EMBALMER: Jack Henderson — LICENSE NO.: E - 349

FIRM NAME: HENDERSON FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 8 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 1 1976

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 15 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5331
Local Reg. No. 365
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hillcrest Haven Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Pocatello
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 1207 E. Bridger

3. NAME OF DECEASED (Type or Print): a. (First) MARGARET b. (Middle) Ann c. (Last) BIEKER

4. DATE OF DEATH (Month) (Day) (Year): Dec. 30, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: April 19, 1894

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frank Schmidtberger
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Margaret Giest
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Henry Bieker
ADDRESS: Pocatello, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Diabetes mellitus
INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): (2) Anemia, secondary (3) Ventral hernia.
INTERVAL BETWEEN ONSET AND DEATH: Years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Chronic uremia
INTERVAL BETWEEN ONSET AND DEATH: Months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 13, 1961 *to* Dec. 30, 1967, *that I last saw the deceased alive on* Dec. 30, 1967, *and that death occurred at* 11:30 a m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 566 (Degree or title), ARCH WIGLE, M. D.

23b. ADDRESS: 1605 North Arthur Pocatello, Idaho 83201

23c. DATE SIGNED: 1-4-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Jan. 3, 1968

24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cem.

24d. LOCATION (City, town, or county) (State): Pocatello, Idaho

DATE REC'D BY LOCAL REGISTRAR: JAN 9 1968

REGISTRAR'S SIGNATURE: Eloise Hopkins

25. EMBALMER: John P. Downard

LICENSE NO.: E-292

FIRM NAME: Downard Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

NOV 30 1987

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5332
Local Reg. No. 360
Reg. Dist. No. 510

BIRTH NO.

RECEIVED JAN 8 1968 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN: Pocatello
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION: St. Anthony Hospital 019

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 031 Bannock
c. CITY OR TOWN: Pocatello
d. STREET ADDRESS (If rural, give location): 645½ North Sixth Avenue

3. NAME OF DECEASED (Type or Print): a. (First) FRANK b. (Middle) L. c. (Last) LOWELLS

4. DATE OF DEATH: (Month) Dec. (Day) 31, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED: Married 3
8. DATE OF BIRTH: Oct. 14, 1885
9. AGE (In years last birthday): 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheepherder 04
10b. KIND OF BUSINESS OR INDUSTRY: Sheep
11. BIRTHPLACE (State or foreign country): Oklahoma
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 16 0762A
17. INFORMANT'S OWN SIGNATURE: Mrs. Ruby Lowells ADDRESS: Pocatello

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia & Pleural effusion — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Myocardial insuficiency — Years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19 6/19, to 31 Jan, 1967, that I last saw the deceased alive on 31 Jan, 1967, and that death occurred at 4:50 p.m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] 406 (Degree or title)
23b. ADDRESS: 373 W Lewis Pocatello Ida
23c. DATE SIGNED: 4 Jan 68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jan. 3, 1968
24c. NAME OF CEMETERY OR CREMATORY: Mountainview Cemetery
24d. LOCATION (City, town, or county) (State): Pocatello, Bannock, Idaho

DATE REC'D BY LOCAL REG. JAN 5 1968
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature] LICENSE NO. E418
FIRM NAME: Manning Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 9 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5333
Local Reg. No. 366
Reg. Dist. No. 510

67-11614 RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

JAN 15 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bannock 031
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bannock Memorial Hospital 018

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bannock 031
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Pocatello
d. STREET ADDRESS (If rural, give location): 4519 Hawthorne

3. NAME OF DECEASED (Type or Print)
a. (First): BRIAN
b. (Middle): ALMA
c. (Last): CAMPBELL

4. DATE OF DEATH (Month) (Day) (Year): Dec. 31, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Dec. 30, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR: Months / Days 1; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02
10b. KIND OF BUSINESS OR INDUSTRY: xxx
11. BIRTHPLACE (State or foreign country): Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: James E. Campbell, Jr. BIRTHPLACE: Florida
14. MOTHER'S MAIDEN NAME: Eva Mae Engberson BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): xxxx
16. SOCIAL SECURITY NO.: xxxx
17. INFORMANT'S OWN SIGNATURE: James E. Campbell, Jr. ADDRESS: Pocatello

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7730

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Hyaline Membrane Disease — INTERVAL BETWEEN ONSET AND DEATH: 1½ days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Patchy pneumonia secondary to above — 1½ days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December 30, 1967, *to* December 31, 1967, *that I last saw the deceased alive on* December 31, 1967, *and that death occurred at* 10:04 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Sydney A. Horrocks, MD. 733
23b. ADDRESS: Center Plaza, Pocatello, Idaho
23c. DATE SIGNED: 1-5-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem-Burial 3
24b. DATE: Jan. 3, 1968
24c. NAME OF CEMETERY OR CREMATORY: Rexburg Cemetery
24d. LOCATION (City, town, or county) (State): Rexburg, Idaho

DATE REC'D BY LOCAL REG.: JAN 9 1968
REGISTRAR'S SIGNATURE: Gloria Dopita
25. EMBALMER: [signature]
LICENSE NO.: E418

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Manning Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 16 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5334
Local Reg. No.
Reg. Dist. No. 552

BIRTH NO.

RECEIVED JAN 2 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bear Lake 040
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Paris Idaho
c. LENGTH OF STAY in this place:
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)
a. STATE: Idaho
b. COUNTY: 041 Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paris
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) David b. (Middle) Edward c. (Last) Beck

4. DATE OF DEATH: (Month) Dec. (Day) 12. (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Dec. 1. 1884

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Paris Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Anders Beck BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Sophia K. Hansen BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-42-7629

17. INFORMANT'S OWN SIGNATURE: Mrs. David Beck ADDRESS: Paris Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Dilatation of Heart — INTERVAL BETWEEN ONSET AND DEATH: about 5 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Myocarditis — about one year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 15, 1967, *to* Dec 12, 1967, *that I last saw the deceased alive on* Dec 12, 1967, *and that death occurred at* 10 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Duncan A Rich M.D. 440
23b. ADDRESS: P.O. Box 126 Paris Idaho
23c. DATE SIGNED: Dec 15-1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Paris Cemetery
24d. LOCATION (City, town, or county) (State): Paris Idaho

DATE REC'D BY LOCAL REG.: 12-15-67
REGISTRAR'S SIGNATURE: Mrs Ruby Gortcinsky
25. EMBALMER: Kile Matthews
LICENSE NO.: E359
FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under JAN 16 1968 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 12 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

JAN 2 1968

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5335

Local Reg. No.

Reg. Dist. No. 552

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bear Lake 040 3-05

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Montpelier

c. LENGTH OF STAY (in this place): 3 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bear Lake Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 040

b. COUNTY: Bear Lake

c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN: Montpelier Idaho

d. STREET ADDRESS (If rural, give location): 432 Huff St.

3. NAME OF DECEASED (Type or Print)

a. (First): Lavinea

b. (Middle): Norris 024

c. (Last): Portela

4. DATE OF DEATH (Month) (Day) (Year): Dec 26 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Mar. 31 1895

9. AGE (In years last birthday): 72

IF UNDER 1 YEAR: Months | Days

IF UNDER 1 HR.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Randolph Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walter Norris — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Rose L. Parker — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: Dyke Portela — ADDRESS: Montpelier Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 1 WK.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 28, 1967, *to* 12-26, 1967, *that I last saw the deceased alive on* 12-26, 1967 *and that death occurred at* 12:40 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Paul E. Reeves M.D.

23b. ADDRESS: Montpelier Idaho

23c. DATE SIGNED: 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec 29 1967

24c. NAME OF CEMETERY OR CREMATORY: Montpelier Cemetery

24d. LOCATION (City, town, or county) (State): Montpelier Idaho

DATE REC'D BY LOCAL REG.: 12-28-67

REGISTRAR'S SIGNATURE: Mrs Ruby Goticinsky

25. EMBALMER: Dale Matthews

LICENSE NO.: E359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5336
Local Reg. No.
Reg. Dist. No. 552

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bear Lake 040 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Charles
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 040 Bear Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Charles
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Albert	A.	Arnell	Dec. 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Feb. 14, 1874	93				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Farmer	04	St. Charles Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Swan Arnell	England	Agnes Pearce	New Jersey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-01-2244	Mrs Almy Barker	St Charles

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular accident. — INTERVAL BETWEEN ONSET AND DEATH: 5 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-31, 1966, *to* 12-27, 1967, *that I last saw the deceased alive on* 12-24, 1967, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Paul B. Reeves MD	Montpelier Ida.	12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 30 1967	St. Charles Cemetery	St. Charles Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-28-67	Mrs Ruby Gontcinski	Dale Matthews	359

FIRM NAME: Matthews Mortuary

Federal Security Agency
United States Public Health Service

Form DH-65021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5337
Local Reg. No. 53
Reg. Dist. No. 130

BIRTH NO. JAN 2 1968

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Benewah 050 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
c. LENGTH OF STAY (in this place) 4 Weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Comm. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harrison
d. STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print)
a. (First) ERIC
b. (Middle) 025 —
c. (Last) LUND

4. DATE OF DEATH (Month) (Day) (Year) Dec. 14 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2 Widowed
8. DATE OF BIRTH 3-11-1878
9. AGE (In years last birthday) 89 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Grader 17
10b. KIND OF BUSINESS OR INDUSTRY Sawmill
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME No information BIRTHPLACE
14. MOTHER'S MAIDEN NAME No information BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-10-5795
17. INFORMANT'S OWN SIGNATURE Alvin R. Lund ADDRESS Harrison Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

33X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 30 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-20, 1967, *to* 12-14, 1967, *that I last saw the deceased alive on* 12-14, 1967, *and that death occurred at* 4:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE W. D. Thurston MD, 533 (Degree or title)
23b. ADDRESS St. Maries Idaho
23c. DATE SIGNED 12-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-18-1967
24c. NAME OF CEMETERY OR CREMATORY Harrison
24d. LOCATION (City, town, or county) (State) Harrison Idaho

DATE REC'D BY LOCAL REG. 12-26-67
REGISTRAR'S SIGNATURE Nanda Dimico
25. EMBALMER Gerald Browning
LICENSE NO. E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

DUTIES:

JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5338
Local Reg. No. 2
Reg. Dist. No. 130

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 9 - 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 050 2-01
a. COUNTY Benewah
b. CITY OR TOWN (If outside corporate limits, write RURAL township) St Maries
c. LENGTH OF STAY (in this place) 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Benewah Comm. Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 050 Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) St. Maries
d. STREET ADDRESS (If rural, give location) FRAndon Hotel

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) 025 A. c. (Last) Smith

4. DATE OF DEATH (Month) (Day) (Year) Dec. 21 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Unknown
8. DATE OF BIRTH March 10, 1882
9. AGE (In years last birthday) 85 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Various
11. BIRTHPLACE (State or foreign country) Austria
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 700-07-0353
17. INFORMANT'S OWN SIGNATURE Don Wetzel GB ADDRESS St Maries

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH 2 hrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1967, *to* Dec 21, 1967, *that I last saw the deceased alive on* Dec 19, 1967, *and that death occurred at* 4:50 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE B. A. Rapp 428 M.D. (Degree or title)
23b. ADDRESS St. Maries, Idaho
23c. DATE SIGNED 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-27-67
24c. NAME OF CEMETERY OR CREMATORY Woodlawn
24d. LOCATION (City, town, or county) (State) St. Maries Idaho

DATE REC'D BY LOCAL REG. 1-4-68
REGISTRAR'S SIGNATURE Wanda Dimico
25. EMBALMER Gerald Browning
LICENSE NO. E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5339
Local Reg. No. 1
Reg. Dist. No. 130

REC'D JAN 9 - 1968
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Benewah 050 2-02
b. CITY OR TOWN St. Maries
LENGTH OF STAY (in this place) 70 days
d. FULL NAME OF HOSPITAL OR INSTITUTION Benewah Comm. Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 050 Benewah
c. CITY OR TOWN St. Maries
d. STREET ADDRESS (If rural, give location) 155 Pine

3. NAME OF DECEASED (Type or Print) a. (First) Maybelle b. (Middle) 035 K. c. (Last) Close
4. DATE OF DEATH (Month) (Day) (Year) Dec. 21 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Aug. 30, 1905
9. AGE (In years last birthday) 62 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse A.D. 13
10b. KIND OF BUSINESS OR INDUSTRY Hospitals
11. BIRTHPLACE (State or foreign country) California
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank Shaw BIRTHPLACE no data
14. MOTHER'S MAIDEN NAME L. James BIRTHPLACE no data

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 572-22-4434
17. INFORMANT'S OWN SIGNATURE Ora May Smith ADDRESS St. Maries

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of the liver — INTERVAL BETWEEN ONSET AND DEATH 6 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1967, *to* Dec 21, 1967, *that I last saw the deceased alive on* Dec 21, 1967, *and that death occurred at* 10:50 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE B. A. Rapp 428 (Degree or title) M.D.
23b. ADDRESS St Maries Ida.
23c. DATE SIGNED 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
24b. DATE 12/23/67
24c. NAME OF CEMETERY OR CREMATORY Hazond Jaeger
24d. LOCATION (City, town, or county) Spokane (State) Wash.

DATE REC'D BY LOCAL REG. 1-4-68
REGISTRAR'S SIGNATURE Wanda Dimiss
25. EMBALMER Gerald Browning LICENSE NO. E-411
FIRM NAME: Browning Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 2 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5340
Local Reg. No. 54
Reg. Dist. No. 130

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Benewah 050
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Desmet
c. LENGTH OF STAY (in this place): lifetime
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At her home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Benewah 050
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Desmet
d. STREET ADDRESS (If rural, give location): --

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) Madgaline c. (Last) Skanen

4. DATE OF DEATH (Month) (Day) (Year): Dec. 25, 1967

5. SEX: female

6. COLOR OR RACE: American Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: July 1 1894

9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife & landowner

10b. KIND OF BUSINESS OR INDUSTRY: Lessor

11. BIRTHPLACE (State or foreign country): Worley, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Not available — BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Not available — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-62-3821

17. INFORMANT'S OWN SIGNATURE: Hillary Skanen — ADDRESS: Desmet, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: weeks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-28, 1967, *to* 12-25-, 1967, *that I last saw the deceased alive on* 12-16, 1967, *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: M D Nepl 803 (Degree or title): MD

23b. ADDRESS: Tekoa Clin Tekoa

23c. DATE SIGNED: 12/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: 12-28-1967

24c. NAME OF CEMETERY OR CREMATORY: Desmet Mission Cemetery

24d. LOCATION (City, town, or county) (State): Desmet, Idaho

DATE REC'D BY LOCAL REG.: 12-28-67

REGISTRAR'S SIGNATURE: Wanda Dennis

25. EMBALMER: H E Kimball

LICENSE NO.: E 269

FIRM NAME: Kimball Funeral Home, Tekoa, Wa.

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 2 2 2007

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5341
Local Reg. No. 171
Reg. Dist. No. 601

Certificate of Death

RECEIVED
JAN 16 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 060 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley, | LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley, Idaho
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): James
b. (Middle): Garfield
c. (Last): Day

4. DATE OF DEATH (Month) May (Day) 31 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov 1881
9. AGE (In years last birthday): 85 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Ireton Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Edwin R. Day | BIRTHPLACE: Green County, Wis.,
14. MOTHER'S MAIDEN NAME: Adelia Peebles | BIRTHPLACE: Green County, Wis.,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-34-9335
17. INFORMANT'S OWN SIGNATURE: H. A. Day | ADDRESS: Shelley, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary artery occlusion

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1963, *to* May 31, 1967, *that I last saw the deceased alive on* May 25, 1967, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 339 (Degree or title): [signature] MD
23b. ADDRESS: Shelley Idaho
23c. DATE SIGNED: 1/16/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: June 3, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest
24d. LOCATION (City, town, or county) (State): Shelley Bingham Idaho

DATE REC'D BY LOCAL REG.: Jan. 15, 1968
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Lloyd M Nalder
LICENSE NO.: E275

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

FEB 7 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5342
Local Reg. No. 152
Reg. Dist. No. 600

RECEIVED DEC 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 1yr2mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada 01
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1204 Oakland Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): ANTON
b. (Middle): E.
c. (Last): LARSON

4. DATE OF DEATH (Month) (Day) (Year): November 17 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Sept. 10, 1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Larson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Betty Anderson — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 471 32 9004
17. INFORMANT'S OWN SIGNATURE: Mary Payne — ADDRESS: Med. Records-State Hospital South

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4918

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Bronchio Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Pulmonary embolism — 1 week
DUE TO (c) Pulmonary Congestion — 1 week

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* General Arteriosclerosis

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 Sept., 19 66, *to* 17 Nov, 19 67, *that I last saw the deceased alive on* 17 Nov, 19 67, *and that death occurred at* 4:10p *m., from the causes and on the date stated above.*

23a. SIGNATURE: C. Stillinger M.D. 594 (Degree or title)
23b. ADDRESS: State Hospital South - Blackfoot, Idaho
23c. DATE SIGNED: 30 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 11-19-67
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county) (State): Boise, Ada, Idaho

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Howard Packham
LICENSE NO.: E-338

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Howard Packham Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 20 1967

APR 02 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 18 1967

Certificate of Death

STATE OF IDAHO

State File No. 5343
Local Reg. No. 163
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
c. LENGTH OF STAY (in this place): 30 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route 4

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location): Route 4

3. NAME OF DECEASED (Type or Print): a. (First) JOSEPH b. (Middle) EDGAR c. (Last) SAUNDERS

4. DATE OF DEATH (Month) (Day) (Year): December 2, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: June 20, 1899
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Harrisville, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Joseph W. Saunders — BIRTHPLACE: Utah
14. MOTHER'S MAIDEN NAME: Ella L. Ferrin — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-46-3793
17. INFORMANT'S OWN SIGNATURE: Ida F. Saunders — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. pulmonary emphysema

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 5, 1964 *to* Dec 2, 1967, *that I last saw the deceased alive on* Dec 1, 1967, *and that death occurred at* 8:00a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. Mills Jr 361 (Degree or title): M.D.
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Dec 5, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Riverside-Thomas cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Dec 15, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: L. Dean Hill
LICENSE NO.: E-466
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 25 1980

JUL 17 1986

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5344
Local Reg. No. 161
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 18 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 5-05 minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 930 South Broadway

3. NAME OF DECEASED (Type or Print): a. (First) ROSA b. (Middle) c. (Last) COTTERELL

4. DATE OF DEATH (Month) (Day) (Year): December 3, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: July 10, 1897

9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): house wife

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Council Bluff, Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Bane — BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-26-0554

17. INFORMANT'S OWN SIGNATURE: Rosetta Phillips — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 Months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*: Cardio Valvular disease Severe — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 20, 1967 *to* Dec 3, 1967, *that I last saw the deceased alive on* Dec 3, 1967, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: O. Dean Packer 403 — (Degree or title): M.D. — **23b. ADDRESS**: Blackfoot, Idaho — **23c. DATE SIGNED**: Dec 4, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial — **24b. DATE**: Dec 7, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Grove City cemetery — **24d. LOCATION** (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: Dec 15, 1967 — REGISTRAR'S SIGNATURE: Dorothy J. Jones — **25. EMBALMER**: L. Dean Hill — LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-65021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED.
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5345
Local Reg. No. 165
Reg. Dist. No. 600

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Nursing Home 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle):
c. (Last): Mattson

4. DATE OF DEATH (Month) (Day) (Year): December 6 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: August 6, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Amhult, Sweden
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Mathew Peterson — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Ingred Johnson Bramin — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519 34 0368A
17. INFORMANT'S OWN SIGNATURE: Rodrick Mattson — ADDRESS: Blackfoot, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3318

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Hemorrhage	10 hours
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arterio Sclerosis	2 yrs
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	~~Arteriosclerosis~~ Mortatic enlargement Healing Fract of hip	2 yrs 6 mo

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 65, *to* Dec 6, 19 67, *that I last saw the deceased alive on* Dec 3, 19 67, *and that death occurred at* ? *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 404 M.D.
23b. ADDRESS: Blackfoot Idaho
23c. DATE SIGNED: 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/9/67
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Dec. 15, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Ralph M. Wood [signature]
LICENSE NO.: 413

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5346
Local Reg. No. 160
Reg. Dist. No. 600

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
061
DEC 1 8 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 1-15
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 14yr7mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): State Hospital South 033

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): Unknown

3. NAME OF DECEASED (Type or Print): a. (First) SUSAN b. (Middle) E. c. (Last) CLARK

4. DATE OF DEATH (Month) (Day) (Year): December 10 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: March 26 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Collicott — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 508 09 1541
17. INFORMANT'S OWN SIGNATURE: Mary Payne — ADDRESS: Med. Records-State Hospital South

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — practically no interval years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus — 1964

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 July, 1962, *to* 10 Dec., 1967, *that I last saw the deceased alive on* 10 Dec., 1967 *and that death occurred at* 2:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE: Mary Louise Smith, MD, 594 (Degree or title)
23b. ADDRESS: State Hospital South, Blackfoot
23c. DATE SIGNED: 12 Dec. 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 15, 67
24c. NAME OF CEMETERY OR CREMATORY: Grove city cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Dec. 15 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: C. Dean Hill
LICENSE NO.: E-466

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Sandberg-Hill Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 18 1967

Certificate of Death

STATE OF IDAHO

State File No. 5347
Local Reg. No. 162
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
c. LENGTH OF STAY (in this place): 64 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route 1 DDO

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location): Route 1

3. NAME OF DECEASED (Type or Print): a. (First) SARAH b. (Middle) JANE DEAN c. (Last) CHAPMAN

4. DATE OF DEATH (Month) (Day) (Year): December 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	married	November 1, 1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Woodruff, Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John C. Dean	England	Elizabeth Heward	England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	519-42-7549B		Blackfoot, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Sclerosis — 5 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Recurring Urinary tract infection 2 mo.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19 50, *to* Dec 11, 19 67, *that I last saw the deceased alive on* Dec 11, 19 67, *and that death occurred at* 3:00a.m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Merrill Parker 404 (Degree or title) M.D.	Blackfoot, Idaho	Dec 13, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 14, 67	Groveland cemetery	Blackfoot Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 15, 1967	Dorothy J. Jones	C. Dean Hill	E-466

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Sandberg-Hill Fneral Home

DUTIES:

DEC 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 7 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5348
Local Reg. No. 164
Reg. Dist. No. 600

BIRTH NO.

RECEIVED DEC 18 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (in this place): 6 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 56 North Meridian

3. NAME OF DECEASED (Type or Print): a. (First) TERESA b. (Middle) C. c. (Last) HIGGINSON

4. DATE OF DEATH (Month) (Day) (Year): December 11, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: September 20, 1901

9. AGE (In years last birthday): 75 | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Taylorsville, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John W. Cook — BIRTHPLACE: Taylorsville, Utah

14. MOTHER'S MAIDEN NAME: Sarah J. Wallace — BIRTHPLACE: Salt Lake City, Ut.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9030

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Head Injury — (Intracranial Hemorrhage) — INTERVAL BETWEEN ONSET AND DEATH: 8hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Accidental Fall
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | **19b. MAJOR FINDINGS OF OPERATION**

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Blackfoot, Bingham, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12 - 10 67 10 P. m. 2

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Fell in Bathroom -

22. *I hereby certify that I attended the deceased from* _____, 196[illegible], *to* Dec 11, 1967, *that I last saw the deceased alive on* Dec 11, 1967, *and that death occurred at* 7:00a. m., *from the causes and on the date stated above.*

23a. SIGNATURE: R.M. Withers 569 — (Degree or title): M.D. — **23b. ADDRESS**: Blackfoot, Idaho — **23c. DATE SIGNED**: Dec 12, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial — **24b. DATE**: Dec 15, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Grove City Cemetery — **24d. LOCATION** (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Dec. 15, 1967 — **REGISTRAR'S SIGNATURE**: Dorothy J. Jones — **25. EMBALMER**: [signature] — **LICENSE NO.**: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5349
Local Reg. No. 166
Reg. Dist. No. 601

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JAN 3 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bingham 060 1-14
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Aberdeen
c. LENGTH OF STAY (in this place): 14 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Aberdeen Rt. #1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Aberdeen
d. STREET ADDRESS (If rural, give location): Route #1

3. NAME OF DECEASED (Type or Print)
a. (First): Walter
b. (Middle): Dale
c. (Last): Jeffery

4. DATE OF DEATH (Month) (Day) (Year): Dec. 13, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Nov. 22, 1899
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Laurens, Iowa
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Dudley Martin Jeffery — BIRTHPLACE: Wisconsin
14. MOTHER'S MAIDEN NAME: Katherine King — BIRTHPLACE: Victor, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-40-3127
17. INFORMANT'S OWN SIGNATURE: x Mrs Alice Jeffery — ADDRESS: Aberdeen, Idaho

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Blood Clots
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Aberdeen Bingham Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see him alive, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 5:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE 583 (Degree or title): Carl Staley — Coroner
23b. ADDRESS: 321 E. Walker St. Blackfoot, Idaho
23c. DATE SIGNED: 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial
24d. LOCATION (City, town, or county) (State): Aberdeen Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Howard Packham
LICENSE NO.: E-338

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Howard Packham Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5350
Local Reg. No. 167
Reg. Dist. No. 600

RECEIVED
Bureau of Vital Statistics
JAN 3 1968

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bingham 061 — 3-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
c. LENGTH OF STAY (In this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham Memorial Hospital 029

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): North West Main St.

3. NAME OF DECEASED (Type or Print)
a. (First): WILLIAM
b. (Middle): DAVID
c. (Last): SCOGINGS

4. DATE OF DEATH: (Month) (Day) (Year): December 15, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: August 25, 1898

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rancher 04

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Marysvale, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Philip E. Scogings
BIRTHPLACE: Rockville, Utah

14. MOTHER'S MAIDEN NAME: Mary E. Brown
BIRTHPLACE: Georgia,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.: 518-12-9888

17. INFORMANT'S OWN SIGNATURE: Laura E. Scogings
ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

3318

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Congestive heart failure — 4 weeks
DUE TO (c): Pulmonary Embolus — 2 weeks

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 15, 1967, *to* Dec 15, 1967, *that I last saw the deceased alive on* Dec 15, 1967, *and that death occurred at* 1:45p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M.D.
23b. ADDRESS: Blackfoot, Idaho
23c. DATE SIGNED: Dec 18,67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec 19,67
24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery
24d. LOCATION (City, town, or county) (State): Blackfoot, Idaho

DATE REC'D BY LOCAL REG.: Dec 28, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: C. Dean Hill
LICENSE NO.: E-466
FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUN 1 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 1 1974

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5351
Local Reg. No. 168
Reg. Dist. No. 601

Certificate of Death

RECEIVED JAN 3 1968 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 060 1-70
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley
c. LENGTH OF RESIDENCE (In this place): Ov. 70 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shelley
d. STREET ADDRESS (If rural, give location): 138 North Holmes

3. NAME OF DECEASED (Type or Print)
a. (First): Stanley
b. (Middle): Allen
c. (Last): Lawrence

4. DATE OF DEATH (Month) (Day) (Year): Dec. 19, 1967

5. SEX: Male
6. COLOR OR RACE: AS
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: August 29, 1888
9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): West Jordan, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andrew T. Lawrence — BIRTHPLACE: Sweden
14. MOTHER'S MAIDEN NAME: Elzada Allen — BIRTHPLACE: Provo, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): World War I 3
16. SOCIAL SECURITY NO.: 518-42-9261
17. INFORMANT'S OWN SIGNATURE: Mrs. Thomas Christensen — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 12-19, 1967, *that I last saw the deceased alive on* 12-19, 1967, *and that death occurred at* 3:15 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE 418 (Degree or title): Windell Petty, MD
23b. ADDRESS: Shelley, Idaho
23c. DATE SIGNED: 12-23-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/23/67
24c. NAME OF CEMETERY OR CREMATORY: Shelley Hillcrest
24d. LOCATION (City, town, or county): Shelley (State): Idaho

DATE REC'D BY LOCAL REG.: Dec 28, 1967
REGISTRAR'S SIGNATURE: Dorothy J. Jones
25. EMBALMER: Floyd M Nalder
LICENSE NO.: E-275
FIRM NAME: Nalder Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 10 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 3 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5352
Local Reg. No. 169
Reg. Dist. No. 601

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bingham 061
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot,
LENGTH OF STAY (in this place): 6 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 1 (Groveland) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham 061
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot (Rural)
d. STREET ADDRESS (If rural, give location): Rt. 1 (Groveland)

3. NAME OF DECEASED (Type or Print): a. (First) OLIVER b. (Middle) MEAD c. (Last) BELNAP

4. DATE OF DEATH: (Month) (Day) (Year) December 20, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 28, 1881

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired -- Farming

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Hooper, Weber Co. Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Oliver Belnap
BIRTHPLACE: Springville, Utah

14. MOTHER'S MAIDEN NAME: Margaret Manning
BIRTHPLACE: Ogden, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-10-8518 A

17. INFORMANT'S OWN SIGNATURE: Lawrence C. Belnap
ADDRESS: Moreland, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 260 X Diabetes mellitus — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hernias, inguinal, bilateral — years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 26 July, 1967, *to* 15 Sept, 1967, *that I last saw the deceased alive on* 15 Sept, 1967, *and that death occurred at* 5 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: Walter D Hoge (Degree or title) 234 MD.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: Dec 21, 67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: December 23, 67

24c. NAME OF CEMETERY OR CREMATORY: Moreland cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: Dec 28, 1967

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: E. Dean Hill

LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form VH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Hoyt

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5353
Local Reg. No. 170
Reg. Dist. No. 600

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bingham 061 — JAN 15 1968
b. CITY OR TOWN (If outside corporate limits, write RURAL and give name of township): Blackfoot — c. LENGTH OF STAY IN (this place): Bureau of [illegible] 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bingham county nursing Home 304

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: 061 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blackfoot
d. STREET ADDRESS (If rural, give location): 704 North Shilling

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM — b. (Middle) G. — c. (Last) SORENSEN

4. DATE OF DEATH (Month) (Day) (Year): December 31, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Dec 31, 1967

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mailman 08

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Post Offic

11. BIRTHPLACE (State or foreign country): Hyrum, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Julius Sorensen — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Johanna Ockerman — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mina L Sorensen — ADDRESS: Blackfoot, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 4221 Arteriosclerotic cardiovascular disease with eventual failure. — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Chronic urinary tract infection. — 1 year.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov., 1953, *to* Dec 31, 1967, *that I last saw the deceased alive on* Dec 31, 1967, *and that death occurred at* 9:30p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Walter L Hoyt MD 234 (Degree or title) M.D.

23b. ADDRESS: Blackfoot, Idaho

23c. DATE SIGNED: Jan 3,1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Jan 4, 1968

24c. NAME OF CEMETERY OR CREMATORY: Riverside-Thomas cemetery

24d. LOCATION (City, town, or county) (State): Bingham county Idaho

DATE REC'D BY LOCAL REG.: Jan. 12, 1968

REGISTRAR'S SIGNATURE: Dorothy J. Jones

25. EMBALMER: C. Mansfield — LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Hom

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

FEB 28 1978

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5354
Local Reg. No. 57
Reg. Dist. No. 410

BIRTH NO.

RECEIVED
DEC 28 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and Township): Rural
LENGTH OF STAY (in this place): 1½ years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 5 Miles North west of Craey

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 070 Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural
d. STREET ADDRESS (If rural, give location): 5 miles North west of Carey

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Delma	C.	Yearsley	Nov. 21, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married	April 9, 1899	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife 01		Spring City Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Hogan Peterson	UNK.	Amilia Sorensen	UNK!

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 26 3095	Frank Yearsley	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 15 MIN

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROTIC HEART DIS. — SEV. YRS.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Oct, *1967, to* Nov, *1967, that I last saw the deceased alive on* Nov 13, *1967, and that death occurred at* 6 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Clarence Parkinson 402 (Degree or title)	Box 37 Hailey, Ida	11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 27, 67	Carey Cemetery	Carey Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 27-67	Robert A. Wright	Keith Bird Keith Bird	E 373

Federal Security Agency
United States Public Health Service

Form DH-63021 Rev. (8-67) FIRM NAME: Bird Funeral Home, Hailey, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5355
Local Reg. No.
Reg. Dist. No. 410

BIRTH NO.

REC JAN 9 - 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Blaine 070
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sun Valley Hospital 036

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 070 Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sun Valley
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Edward
b. (Middle): Lee
c. (Last): Kendrick Jr.

4. DATE OF DEATH (Month) (Day) (Year): Dec 29, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: May 27, 1937
9. AGE (In years last birthday): 30 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter 21
10b. KIND OF BUSINESS OR INDUSTRY: Painting
11. BIRTHPLACE (State or foreign country): Yakima, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward Lee Kendrick Sr. — BIRTHPLACE: Unk.
14. MOTHER'S MAIDEN NAME: Inez Buzley — BIRTHPLACE: Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): 1947 4
16. SOCIAL SECURITY NO.: 537 34 3594
17. INFORMANT'S OWN SIGNATURE: From Discharge Papers & Phone — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9934

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cranio-cerebral trauma — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): SKI SLOPE 12
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 BALDY MT (KETCHUM) 070 BLAINE IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? FELL WHILE SKIING

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: A. Scott Earle 583 Coroner 4 (Degree or title)
23b. ADDRESS: Sun Valley, Idaho
23c. DATE SIGNED: 1/2/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Dec. 30, 67
24c. NAME OF CEMETERY OR CREMATORY: Yakima Cemetery
24d. LOCATION (City, town, or county) (State): Yakima, Washington

DATE REC'D BY LOCAL REG.: Jan 6-68
REGISTRAR'S SIGNATURE: Robert H. Wright
25. EMBALMER: Keith Bird Keith Bird — LICENSE NO.: E 373

Federal Security Agency
United States Public Health Service

Form DH-63021 per CBW

FIRM NAME: Bird Funeral Home Hailey, Ida.

NOTICE:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 1 [illegible] 1963

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5356
Local Reg. No. 352
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 29 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boise 080 4-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Near Horseshoe Bend
c. LENGTH OF STAY (in this place): 1½ Hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Stone Ranch 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 011 Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
d. STREET ADDRESS (If rural, give location): 1813 North 19th Street

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): MASTERS
c. (Last): TRUE

4. DATE OF DEATH (Month) (Day) (Year): Dec. 24, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 14, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Hydro-electric Operator-Idaho Power
10b. KIND OF BUSINESS OR INDUSTRY: 09
11. BIRTHPLACE (State or foreign country): Syracuse, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: David W. True, Syracuse, Neb.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Sarah Masters

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 543-18-3757
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Arthur A. Stone, Horseshoe Bend, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: unknown

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic Heart — 10 yrs
DUE TO (c): Diabetes Mellitus — 8 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-25, 1969, *to* 12-14, 1967, *that I last saw the deceased alive on* 12-14, 1967, *and that death occurred at* 5:15 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm D Forney 173 M.D.
23b. ADDRESS: 425 Bannock St
23c. DATE SIGNED: 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-27-67
24c. NAME OF CEMETERY OR CREMATORY: Pioneer Cemetery
24d. LOCATION (City, town, or county) (State): Horseshoe Bend, Idaho

DATE REC'D BY LOCAL REG.: 12/28/67
REGISTRAR'S SIGNATURE: Henrietta Penrod
25. EMBALMER: Fred E. Walker
LICENSE NO.: E-483
FIRM NAME: SUMMERS FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5357
Local Reg. No. 138
Reg. Dist. No. 110

Certificate of Death

RECEIVED
JAN 4 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091 3-07
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 1 week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital 039

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 091 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 601 N. Division

3. NAME OF DECEASED (Type or Print)
a. (First): Hallie
b. (Middle): Elnora
c. (Last): Hunter

4. DATE OF DEATH (Month) (Day) (Year): December 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 28, 1914
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Montana
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Kelso P. Fuller — BIRTHPLACE: no record
14. MOTHER'S MAIDEN NAME: Nora Bostick — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO.: 520-10-5604
17. INFORMANT'S OWN SIGNATURE: Leona O'Dea — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

154X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of rectum with metastases — INTERVAL BETWEEN ONSET AND DEATH: 3 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 9/23/66
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of rectum, extensive
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 8, 1966, *to* Dec. 7, 1967, *that I last saw the deceased alive on* Dec. 6, 1967, *and that death occurred at* 9:05a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Kelvin Peterson 415 Md
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 12/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: County Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint, Idaho

DATE REC'D BY LOCAL REG.: Dec. 21, 1967
REGISTRAR'S SIGNATURE: Phyllis Y. Tibbetts
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5358
Local Reg. No. 141
Reg. Dist. No. 110

Certificate of Death

RECEIVED
JAN 4 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 090 1-36
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Priest River
c. LENGTH OF STAY (in this place): 36 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 090 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Priest River
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Sylvia
b. (Middle): Mae
c. (Last): Neil

4. DATE OF DEATH (Month) (Day) (Year): Dec 10 1967

5. SEX: Fe
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 5/27/1914
9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk 25
10b. KIND OF BUSINESS OR INDUSTRY: Dry Goods Store
11. BIRTHPLACE (State or foreign country): Moscow Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Ephriam Byers
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Johanna Carter

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 26 6063
17. INFORMANT'S OWN SIGNATURE — ADDRESS: J A Neil — Priest River Idaho

18. CAUSE OF DEATH 4281
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-10-49, 19__, *to* 12-10-67, 19__, *that I last saw the deceased alive on* 9-16, 1966, *and that death occurred at* 5:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert Warren Winston 608 MD
23b. ADDRESS: Newport, Wash.
23c. DATE SIGNED: 12/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/14/67
24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery
24d. LOCATION (City, town, or county) (State): Priest River Idaho

DATE REC'D BY LOCAL REG.: Dec. 29, 1967
REGISTRAR'S SIGNATURE: Phyllis G. Tilchette
25. EMBALMER: R. D. Sherman
LICENSE NO.: QL749

Federal Security Agency
United States Public Health Service
Form OH-63021
FIRM NAME: Sherman Funeral Home, Inc.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendent. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5359
Local Reg. No. 136
Reg. Dist. No. 110

BIRTH NO.

JAN 4 1968

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonner 091 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 091 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 514 Fir Street

3. NAME OF DECEASED (Type or Print): a. (First) John b. (Middle) 039 Anton c. (Last) Selberg, Sr.

4. DATE OF DEATH (Month) (Day) (Year): December 12, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married

8. DATE OF BIRTH: Aug. 18, 1890

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Sweden

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Selberg
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Frieda
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): WW I 3

16. SOCIAL SECURITY NO.: 518-03-8849

17. INFORMANT'S OWN SIGNATURE: X LeRoy P. Selberg
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Vascular accident and Myocardial infarction
INTERVAL BETWEEN ONSET AND DEATH: ↑ 7 Hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Lt Carotid occlusion

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

331X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11/12, 1965, *to* 12/12, 1967, *that I last saw the deceased alive on* 12/11/67, 19___, *and that death occurred at* 845A m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] M.D. (Degree or title)

23b. ADDRESS: [illegible] Sandpoint

23c. DATE SIGNED: 12/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 15, 1967

24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery

24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1967

REGISTRAR'S SIGNATURE: Kayllis G. Tibbetts

25. EMBALMER: Dale G. Coffelt
LICENSE NO.: E-501

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 5 1968

JAN 12 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 4 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5360
Local Reg. No. 137
Reg. Dist. No. 110

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 090 1-208
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cocolalla
c. LENGTH OF STAY (in this place): 20 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 091 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Sandpoint
d. STREET ADDRESS (If rural, give location): Star Route - Cocolalla

3. NAME OF DECEASED (Type or Print)
a. (First): Fred
b. (Middle): Grinham
c. (Last): Knauss

4. DATE OF DEATH (Month) (Day) (Year): December 12, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 30, 1897
9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer - Retired 04
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): North Dakota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Daniel J. Knauss — BIRTHPLACE: Pennsylvania
14. MOTHER'S MAIDEN NAME: Kate Grinham — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W. W. I 3
16. SOCIAL SECURITY NO.: 532-32-3968
17. INFORMANT'S OWN SIGNATURE: Sara A. Knauss — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Sudden death - Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic Heart Disease — years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Aortic aneurysm

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9/13, 1956, *to* 12/12, 1967, *that I last saw the deceased alive on* 12/7, 1967 *and that death occurred at* 4:30 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Frank Grinham 471 W.
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 12/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pinecrest Cemetery
24d. LOCATION (City, town, or county) (State): Sandpoint Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1967
REGISTRAR'S SIGNATURE: Phyllis G. Tibbetts
25. EMBALMER: Dale G. Coffelt — LICENSE NO.: E-501

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Moon Funeral Home

JAN 12 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 4 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5361
Local Reg. No. 140
Reg. Dist. No. 110

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 090 1-21
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blanchard
LENGTH OF STAY (in this place): 21 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 090 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Blanchard
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Genevieve b. (Middle) Morene c. (Last) Morse

4. DATE OF DEATH: (Month) Dec (Day) 14 (Year) 1967

5. SEX: Fe
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 10 1899
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Washington
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: John N. Morse — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Gertrude Applington — BIRTHPLACE: Washington
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 531 24 3285
17. INFORMANT'S OWN SIGNATURE: Spirit Lake ADDRESS: Carroll E Morse Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Donn D. Nelson 583 (Degree or title): Coroner
23b. ADDRESS: Sandpoint, Idaho
23c. DATE SIGNED: 12/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/19/67
24c. NAME OF CEMETERY OR CREMATORY: Blanchard Cemetery
24d. LOCATION (City, town, or county) (State): Blanchard, Idaho

DATE REC'D BY LOCAL REG.: Dec 29, 1967
REGISTRAR'S SIGNATURE: Phyllis Gulbertson
25. EMBALMER: C. E. Sherman
LICENSE NO.: QL 155

Federal Security Agency
United States Public Health Service
Form DH-6-2021
FIRM NAME: Sherman Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5362
Local Reg. No. 139
Reg. Dist. No. 110

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonner 091 — JAN 4 1968 — 1-05
b. CITY OR TOWN: Sandpoint
c. LENGTH OF STAY (in this place): 5 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1312 Superior

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 091 Bonner
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
d. STREET ADDRESS (If rural, give location): 1312 Superior

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Jesse	James	Stokes	Dec. 17, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	March 24, 1898	69	- -	- - - -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 64	Own Farm	Utah	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Stokes	England	Eliza A. Young	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	- - - - - - - - -	519-38-7979 J	X Mary Stokes	Sandpoint, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro-vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Same

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 10 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - - - - - -	- - - - - - - - - - - - - - - - - -	- - - - - - - - - - - - - - - - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
- - - - - - - - - - m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	- - - - - - - - - - - - - - - - - - -

JUN 13 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5363
Local Reg. No.
Reg. Dist. No. 110

RECEIVED JAN 18 1968 Bureau of V.S.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonner 091 2-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint
c. LENGTH OF STAY (in this place): 6 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sandpoint Manor 262

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 27 Montana
b. COUNTY: 555 Sanders
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Noxon
d. STREET ADDRESS (If rural, give location): --

3. NAME OF DECEASED (Type or Print): a. (First) Lillie b. (Middle) B. c. (Last) Cotton

4. DATE OF DEATH: (Month) (Day) (Year) December 30, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Jan. 21, 1884

9. AGE (In years last birthday): 83 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Freman C. Jenkins
BIRTHPLACE: No record

14. MOTHER'S MAIDEN NAME: Agnes E. Moore
BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): --

16. SOCIAL SECURITY NO.: 516-24-6006

17. INFORMANT'S OWN SIGNATURE: Brice Green by LDM Jr
ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 3327 Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis — 8 years.

DUE TO (c) Hypertension — 15 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-10, 1956 *to* 12-28, 1967, *that I last saw the deceased alive on* 12-26, 1967, *and that death occurred at* 11:20 *m., from the causes and on the date stated above.*

23a. SIGNATURE: John W. Smith 480 (Degree or title): MD.
23b. ADDRESS: Sandpoint Idaho
23c. DATE SIGNED: 1-5-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Jan. 5, 1968
24c. NAME OF CEMETERY OR CREMATORY: Heron Cemetery
24d. LOCATION (City, town, or county): Heron (State): Montana

DATE REC'D BY LOCAL REG.: Jan. 10, 1968
REGISTRAR'S SIGNATURE: Phyllis Y. Williams

25. EMBALMER: L. C. Moon, Jr.
LICENSE NO.: E-405

FIRM NAME: Moon Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5364
Local Reg. No. 337
Reg. Dist. No. 611

RECEIVED JAN 16 1968 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 100
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Iona
c. LENGTH OF STAY (in this place): 1-00 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 100 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Iona
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Orlie b. (Middle) Johnson c. (Last) Denning

4. DATE OF DEATH (Month) (Day) (Year): November 4 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: June 20, 1898

9. AGE (In years last birthday): 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Tooele, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Nels J. Johnson
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Agnes Murray
BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 519 44 1041A

17. INFORMANT'S SIGNATURE: Wendell J. Denning
ADDRESS: Richfield, Utah

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 1533 Carcinoma of sigmoid & metastases. — INTERVAL BETWEEN ONSET AND DEATH: 9 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Annular Ca of sigmoid

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb., 19 56, *to* Oct., 19 67, *that I last saw the deceased alive on* Oct. 25, 19 67, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leonard J. Bingham MD

23b. ADDRESS: P.O. Box 2438 Idaho Falls Idaho 83401

23c. DATE SIGNED: Jan. 6, 1968

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11/8/67

24c. NAME OF CEMETERY OR CREMATORY: Iona Cemetery

24d. LOCATION (City, town, or county) (State): Iona Bonneville Co. Idaho

DATE REC'D BY LOCAL REG.: Jan 10 - 68

REGISTRAR'S SIGNATURE: Irma Bridges

25. EMBALMER: Ralph M. Wood Ralph M Wood
LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

APR 18 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 31 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5365
Local Reg. No. 375
Reg. Dist. No. 6-D

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place): 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter day Saints Extended Care Unit 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Woodville
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Andrew b. (Middle) c. (Last) McDonald

4. DATE OF DEATH (Month) (Day) (Year): November 19 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	May 17, 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Sheepherder	Sheep	Scotland	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 28 2437	Hospital Records	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Congestive Heart Failure	3 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arterio sclerotic heart disease	many years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Cerebral arteriosclerosis with Chronic brain syndrome	

4200

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 19 June 64, 19___, *to* 19 Nov, 1967, *that I last saw the deceased alive on* 13 Nov, 1967, *and that death occurred at* 11:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Kim O. Johnson	MD	Idaho Falls Idaho	16 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	11/22/67	Rose Hill Cemetery	Idaho Falls Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 19-1967	Emma Rudges	Ralph M. Wood Ralph M Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5366
Local Reg. No. 360
Reg. Dist. No. 616

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bonneville 101 — JAN 2 1968 000

b. CITY OR TOWN: Idaho Falls,

c. LENGTH OF STAY: Bureau of Vital Statistics

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY: 101 Bonneville

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls Idaho

d. STREET ADDRESS (If rural, give location): 840 East Elva

3. NAME OF DECEASED (Type or Print): a. (First) ALMA — b. (Middle) LOUISE — c. (Last) TURK

4. DATE OF DEATH: (Month) (Day) (Year) Nov. 28, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Wid.

8. DATE OF BIRTH: Jan. 10, 1894

9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Newberry, Michigan

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew Hedberg, — BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Emma Stromberg, — BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 380-38-7271

17. INFORMANT'S OWN SIGNATURE: Elton H. Turk — ADDRESS: 535 12th, Ida. Falls, I.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: Years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Diabetes mellitus — INTERVAL BETWEEN ONSET AND DEATH: Years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14, 1966, *to* 11-28, 1967, *that I last saw the deceased alive on* 11-28, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 546 (Degree or title)

23b. ADDRESS Idaho Falls, Idaho

23c. DATE SIGNED 12/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Nov. 30, 1967

24c. NAME OF CEMETERY OR CREMATORY: Newberry Cemetery

24d. LOCATION (City, town, or county) (State): Newberry, Michigan

DATE REC'D BY LOCAL REG.: Dec. 18-1967

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: [signature]

LICENSE NO.: E 387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

BIRTH NO. 67-10693

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 3 1968 Bureau of Vital Statistics

State File No. 5367
Local Reg. No. 388
Reg. Dist. No. 610

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 1-16
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 16 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Rd # 5

3. NAME OF DECEASED (Type or Print)
a. (First): RAYMOND
b. (Middle): LEON
c. (Last): HAGAN JR.

4. DATE OF DEATH (Month) (Day) (Year): November 28-1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Nov. 12, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months Days 16; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NOne 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Raymond Leon Hagan
BIRTHPLACE: Lexington, Neb
14. MOTHER'S MAIDEN NAME: Sharron Chainhalt
BIRTHPLACE: Denver, Colo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Raymond L. Hagan
ADDRESS: Rt. 5, IDa. Falls

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7541

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 20 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Patent ductus arteriosis Congenital — 20 days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Infarction, acute, right kidney; Septicemia; Acute brain edema — unknown

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8 Nov., 1967, *to* 28 Nov., 1967, *that I last saw the deceased alive on* 28 Nov., 1967, *and that death occurred at* 7:30 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Kim O. Johnson 262 (Degree or title) MD
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 15 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Nov. 30, 67
24c. NAME OF CEMETERY OR CREMATORY: Fielding Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 29-67
REGISTRAR'S SIGNATURE: Anna Budgee
25. EMBALMER: Bill Sullivan
LICENSE NO.: E 387

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck Funeral Home

DUTIES:

JAN 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Robert Rubidoux 1748 Dogwood

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5368
Local Reg. No. 367
Reg. Dist. No. 610

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
JAN 2 1968
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
c. LENGTH OF STAY (In this place): 2 days.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 100
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Roberts
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) FRANK b. (Middle) JOSEPH c. (Last) VOPAT

4. DATE OF DEATH: (Month) Nov. (Day) 29. (Year) 1967

5. SEX: Male

6. COLOR OR RACE: Caucasoid

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single

8. DATE OF BIRTH: Nov. 9, 1890

9. AGE (In years last birthday): 77
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 01

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Prague, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME — BIRTHPLACE: Vaclav Vopat, Czechecoslavakia

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Joana Tomchak, Czechoslavakia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): World I 3

16. SOCIAL SECURITY NO.: Unk.

17. INFORMANT'S OWN SIGNATURE: Stanley J. Vopat. ADDRESS: 16[illegible] Melrose Park, Ill

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).
**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Art. Scl. Heart Disease
DUE TO (c) Senility

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Frostbite Hands & Feet

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. L. Nielsen, M.D. 390

23b. ADDRESS: Idaho Falls

23c. DATE SIGNED: 12-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Dec. 1, 1967

24c. NAME OF CEMETERY OR CREMATORY: Mnt. Carmel Cemetery

24d. LOCATION (City, town, or county) (State): Melrose Park, Illinois

DATE REC'D BY LOCAL REG.: Dec. 16-1967

REGISTRAR'S SIGNATURE: Emma Rudger

25. EMBALMER: Buck Ludwig

LICENSE NO.: E 387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 13 1968

FEB 23 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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1543 S Blvd

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5369
Local Reg. No. 376
Reg. Dist. No. 610

BIRTH NO.

JAN 2 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101 1-11
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 11yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hosp. (doa) 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
d. STREET ADDRESS (If rural, give location) 275 5th St.

3. NAME OF DECEASED (Type or Print)
a. (First) TED
b. (Middle) FRANCIS
c. (Last) ELLIS

4. DATE OF DEATH (Month) (Day) (Year) Nov. 30. 1967

5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 23, 1900
9. AGE (In years last birthday) 67 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY Real Estate
11. BIRTHPLACE (State or foreign country) Dubois, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ted Daniel Ellis — BIRTHPLACE Salt Lake C, Ut.
14. MOTHER'S MAIDEN NAME Daisy E. Foyle — BIRTHPLACE Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) None (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 520-20-1591
17. INFORMANT'S OWN SIGNATURE Maemie R. Ellis — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerotic heart
DUE TO (c) disease — 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July 1964, *19*___, *to* Sept., *19* 67, *that I last saw the deceased alive on* 9-13-67, *19*___, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 210 (Degree or title) M.D.
23b. ADDRESS 1050 Memorial Dr. Idaho Falls, Idaho.
23c. DATE SIGNED 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/4//67
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) Idaho Falls, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 16 1967
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER [signature]
LICENSE NO. E 387

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Buck Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5370
Local Reg. No. 377
Reg. Dist. No. 610

BIRTH NO.

JAN 2 1968

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY: Bonneville 101 3-02

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

c. LENGTH OF STAY (In this place): 2 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bonneville 100

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Roberts

d. STREET ADDRESS (If rural, give location): Box 235

3. NAME OF DECEASED (Type or Print)

a. (First): Robert

b. (Middle): Francis

c. (Last): Stewart

4. DATE OF DEATH (Month) (Day) (Year): Dec. 1, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 6, 1914

9. AGE (In years last birthday): 53 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber 21

10b. KIND OF BUSINESS OR INDUSTRY: Self, Retired

11. BIRTHPLACE (State or foreign country): Boise, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Stewart, BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Nellie Wiebelhaus, BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): World II 4

16. SOCIAL SECURITY NO.: 540-34-1219

17. INFORMANT'S OWN SIGNATURE: J. Yvonne Stewart, ADDRESS: Roberts, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Diabetic acidosis & Coma

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 1, 1967, *to* Dec 2, 1967, *that I last saw the deceased alive on* Dec 1, 1967, *and that death occurred at* 12:15 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Byron T Weeks MD 556

23b. ADDRESS: 1585 So. Boulevard

23c. DATE SIGNED: 12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-4-67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill #Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 19-1967

REGISTRAR'S SIGNATURE: Anna Budges

25. EMBALMER: Bill Sullivan

LICENSE NO.: E 387

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

DUTIES: JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Hansen

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5371
Local Reg. No. 378
Reg. Dist. No. 610

BIRTH NO.

JAN 2 1968

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LIMITS OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Handy Cabins Idaho Falls

3. NAME OF DECEASED (Type or Print)
a. (First): Edward
b. (Middle):
c. (Last): Hess

4. DATE OF DEATH (Month) (Day) (Year): Dec. 2, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): unknown
8. DATE OF BIRTH: Nov 14, 1884
9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months 0, Days 18 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ?
12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: ? BIRTHPLACE:
14. MOTHER'S MAIDEN NAME: ? BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-24-6435
17. INFORMANT'S OWN SIGNATURE: Hospital Records. ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ruptured ~~Ruptu~~ duodenal ulcer

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION: Ruptured ulcer Oct 67
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Idaho Falls, Ida

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1967, *to* Dec 2, 1967, *that I last saw the deceased alive on* Dec 1, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

200

23a. SIGNATURE (Degree or title): D. L. Hansen M.D.
23b. ADDRESS: Idaho Falls
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 20-67
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Leo A Williams
LICENSE NO.: E-319

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Williams Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5372
Local Reg. No. 380
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
DEC 29 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley,
d. STREET ADDRESS (If rural, give location) R#1

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Neville c. (Last) Lang

4. DATE OF DEATH (Month) Dec (Day) 3 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH Nov 2 1894

9. AGE (In years last birthday) 73 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter 21

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Albany New York

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Micheal Angelo Lang BIRTHPLACE New York

14. MOTHER'S MAIDEN NAME Frances Elizabeth Neville Byrne, BIRTHPLACE New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW I Yes WW I 3

16. SOCIAL SECURITY NO. 518-09-5973

17. INFORMANT'S OWN SIGNATURE Charles N. Lang Jr. ADDRESS

330X

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Intracranial hemorrhage

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) from ruptured aneurysm

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1961, *to* 12-3, 1967, *that I last saw the deceased alive on* 12-3, 1967, *and that death occurred at* 5:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE 4/18 Wendell (Degree or title) 23b. ADDRESS Shelley, Idaho 23c. DATE SIGNED 12-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 24b. DATE 12-6-67 24c. NAME OF CEMETERY OR CREMATORY Elmwood, 24d. LOCATION (City, town, or county) Gooding Gooding, (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 22-1967 REGISTRAR'S SIGNATURE Anna Budge

25. EMBALMER Floyd McNabb LICENSE NO. E275

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 29 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased. FEB 6 1984

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5373
Local Reg. No. 371
Reg. Dist. No. 610

BIRTH NO.

RECEIVED DEC 15 1967

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau Precinct) Idaho Falls
c. LENGTH OF STAY (In this place) 1 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewisville
d. STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print) a. (First) WILLIAM b. (Middle) LEONARD c. (Last) JARDINE

4. DATE OF DEATH (Month) (Day) (Year) Dec. 3, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Feb. 4, 1907
9. AGE (In years last birthday) 60 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 21
10b. KIND OF BUSINESS OR INDUSTRY Paint
11. BIRTHPLACE (State or foreign country) Lewisville, Idaho.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edmond LaRoy Jardine BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Mae Arrowsmith BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-07-4704
17. INFORMANT'S OWN SIGNATURE Eva Jardine ADDRESS Lewisville, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Adenocarcenoma Metastatic to spine & lungs — INTERVAL BETWEEN ONSET AND DEATH 6 mos

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) adeno carcinoma rectum — 1½ yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 5-19-66
19b. MAJOR FINDINGS OF OPERATION adenocarcenoma rectum
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5-18, 1966, to 12-3, 1967, that I last saw the deceased alive on 12-3, 1967, and that death occurred at 5:30 P M, from the causes and on the date stated above.

23a. SIGNATURE J H Carr 081 (Degree or title) M.D.,
23b. ADDRESS Idaho Falls, Idaho.
23c. DATE SIGNED 12-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 6, 1967
24c. NAME OF CEMETERY OR CREMATORY Lewisville
24d. LOCATION (City, town, or county) (State) Lewisville Jefferson Ida.

DATE REC'D BY LOCAL REG. Dec 11-1967
REGISTRAR'S SIGNATURE Emma Bredger
25. EMBALMER Bruce A. Eckersell LICENSE NO. E-404
FIRM NAME Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 19 1967

JAN 16 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5374
Local Reg. No. 373
Reg. Dist. No. 610

RECEIVED
DEC 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
DURATION OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Enroute to Hospital from Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 624 East May

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Catherine		Campbell	December 4 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	August 15, 1908	59				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Presser 21	Laundry	Kemmerer, Wyoming	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Jones	England	Louise Williams	Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 24 0307	Maude A Polson	Idaho Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

460X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary (possible) embolism — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Surgery for varicose ulcer (skin graft) and vein stripping, 11-27-67
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
		Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan. , 1955, *to* 12-4, 19 67, *that I last saw the deceased alive on* 12-4, 19 67, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
R B Davis 156 (Degree or title)	Idaho Falls, Idaho	12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/8/67	Thomas Cemetery	Thomas Bingham County Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 16-1967	Anna Rudgers	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 24 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAY 29 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 20 1967 Bureau of Vital Statistics

State File No. 5375
Local Reg. No. 374
Reg. Dist. No. 616

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 24 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 305 8th Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 305 8th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	E.	Humpherys	December 5 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	September 17, 1879	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Paris, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John James Humpherys	England	Mary Ann Smith	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519 20 9128	Cleo Carley Harris	Salt Lake City UT.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A S H D.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. H. Baker 018 M.D.	Idaho Falls	12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/8/67	Hillcrest Cemetery	Shelley Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 15-1967	Irma Burgess	Ralph M. Wood Ralph M. Wood	413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5376
Local Reg. No. 401
Reg. Dist. No. 610

RECEIVED JAN 16 1968 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Bonneville 101

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

c. LENGTH OF STAY (in this place): 8 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Bonneville 101

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

d. STREET ADDRESS (If rural, give location): 143 3rd Street

3. NAME OF DECEASED (Type or Print)

a. (First): Cyrus

b. (Middle): E.

c. (Last): Jacobson

4. DATE OF DEATH (Month) (Day) (Year): December 7 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: May 19, 1880

9. AGE (In years last birthday): 87

IF UNDER 1 YEAR — Months / Days

IF UNDER 24 HRS. — Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Hyrum, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob E. Jacobson

BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Cecelia McBride

BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 60 5910J1

17. INFORMANT'S OWN SIGNATURE: C. Brial Jacobson

ADDRESS: Jackson, Wyoming

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis 332

INTERVAL BETWEEN ONSET AND DEATH: 1 Week

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Chronic Lymphocytic Leukemia

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Feb. 27, 1956, *to* Dec. 6, 1967, *that I last saw the deceased alive on* Dec. 6 1967, *and that death occurred at* 2:50A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): L.K. Krantz M.D.

23b. ADDRESS: 798 South Blvd. Idaho Falls, Idaho

23c. DATE SIGNED: 1/16/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/11/67

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park

24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Jan. 16-1968.

REGISTRAR'S SIGNATURE: Irma Budge

25. EMBALMER: Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 3 1968 Bureau of Vital Statistics

State File No. 5377
Local Reg. No. 374
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 1-30
b. CITY OR TOWN Idaho Falls | LENGTH OF STAY (In this place) 30 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho | b. COUNTY 100 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Roberts
d. STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print) a. (First) FERDINAND b. (Middle) MONTE c. (Last) SR.

4. DATE OF DEATH (Month) 12 (Day) 9 (Year) 67

5. SEX Male | 6. COLOR OR RACE Cauc. | 7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Wid.

8. DATE OF BIRTH Dec 12, 1891

9. AGE (In years last birthday) 75 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Summun, Poland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Ferdinand Monte | BIRTHPLACE Summun, Poland

14. MOTHER'S MAIDEN NAME Eva Winters | BIRTHPLACE Summun, Poland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Mrs. Wm (Amelia) Lawson | ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Adenocarcinoma

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Adenocarcinoma Stomach

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Marrow depression from cancer Chemo therapy

INTERVAL BETWEEN ONSET AND DEATH: about one year

19a. DATE OF OPERATION 11-14-67

19b. MAJOR FINDINGS OF OPERATION almost 100% involvement Stomach with Carcinoma & metastases

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan 12, 1967, *to* 12-8, 1967, *that I last saw the deceased alive on* 12-8, 1967, *and that death occurred at* 7:14 A m., *from the causes and on the date stated above.* 12-9-67

23a. SIGNATURE Harr MD (Degree or title)

23b. ADDRESS 756 OXFORD, Idaho Falls

23c. DATE SIGNED 12-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-12-67

24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery

24d. LOCATION (City, town, or county) Idaho Falls, Ida. (State)

DATE REC'D BY LOCAL REG. Dec. 29-'67

REGISTRAR'S SIGNATURE Irma Budge

25. EMBALMER Bruce Sullivan

LICENSE NO. E 387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 21 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5378
Local Reg. No. 389
Reg. Dist. No. 610

RECEIVED JAN 10 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 — 2-01
b. CITY OR TOWN: Idaho Falls
c. LENGTH OF STAY IN THIS PLACE: 4 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 260 Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Terreton
d. STREET ADDRESS (If rural, give location): Terreton

3. NAME OF DECEASED (Type or Print): a. (First) JESSIE b. (Middle) LORA c. (Last) GERARD

4. DATE OF DEATH: (Month) (Day) (Year) Dec. 10, 1967

5. SEX: Female

6. COLOR OR RACE: cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Wid.

8. DATE OF BIRTH: July 7, 1884

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): O'Fallon, Illinois

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew B. Shelton — BIRTHPLACE: Kentucky

14. MOTHER'S MAIDEN NAME: Caroline M. Party — BIRTHPLACE: Uknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518-12-0801

17. INFORMANT'S OWN SIGNATURE: X Jack Gerard — ADDRESS: Terreton, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Uremia	10 days
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Multiple myeloma	6 mos
DUE TO (c)	Severe anemia	2 mos
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Arteris-sclerotic heart disease	4 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-22, 1966, *to* Dec 10, 1967, *that I last saw the deceased alive on* 12-10, 1967, *and that death occurred at* 10 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hoyt B. Woolley M.D. 641

23b. ADDRESS: 195 So Skyline Dr

23c. DATE SIGNED: 12/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 13, 67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 4-68

REGISTRAR'S SIGNATURE: Irma Burgess

25. EMBALMER: Bill Sullivan — LICENSE NO.: E 387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5379
Local Reg. No. 385
Reg. Dist. No. 610

RECEIVED JAN 3 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 (1-65)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 65 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville 101
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): 500 L Street

3. NAME OF DECEASED (Type or Print): a. (First) MARY b. (Middle) LYDIA c. (Last) LAMBERSON

4. DATE OF DEATH: (Month) DEC. (Day) 13, (Year) 1967

5. SEX: Fem.

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: July 25, 1885

9. AGE (In years last birthday): 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Manti, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Lee Bybee
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Lydia Alzina Foryush
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: 500 L St. IF, I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4907 Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Parkinsonism — 1 year

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-7, 1967, *to* 12-13, 1967, *that I last saw the deceased alive on* 12-13, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 546 (Degree or title) MD

23b. ADDRESS: Idaho Falls Ida

23c. DATE SIGNED: 12/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12,18, 1967

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Ida.

DATE REC'D BY LOCAL REG.: Dec. 29-67

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: [signature] LICENSE NO. E 387

FIRM NAME: Buck Funeral HOme

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5380
Local Reg. No. 391
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 JAN 2 1968
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Vital Statistics Bureau district): Idaho Falls 000
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1525 Glen Arber Place 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 1525 Glen Arber Place

3. NAME OF DECEASED (Type or Print): a. (First) MARY ANN b. (Middle) VIRGIN c. (Last) MUIR

4. DATE OF DEATH: (Month) (Day) (Year) December 15, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: October 10, 1882
9. AGE (In years last birthday): 85 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Fish Haven, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Amos Moses Virgin Marston, BIRTHPLACE: Bedfordshire, England
14. MOTHER'S MAIDEN NAME: Sarah Francis Merkley BIRTHPLACE: Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-60-6641T1
17. INFORMANT'S OWN SIGNATURE: Bertha Muir ADDRESS: Idaho Falls, I

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Carcinoma, Generalized — INTERVAL BETWEEN ONSET AND DEATH: Two years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Anorexia; Dehydration; Multiple Decubiti Skin

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-1, 1967, *to* 12-15, 1967, *that I last saw the deceased alive on* 12-15, 1967, *and that death occurred at* 9:20 p *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 779 (Degree or title):
23b. ADDRESS: 9th & Orford Idaho Falls
23c. DATE SIGNED: 12-19 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/19/67
24c. NAME OF CEMETERY OR CREMATORY: Sugar City
24d. LOCATION (City, town, or county) (State): Sugar City Madison Idaho

DATE REC'D BY LOCAL REG.: Dec 23-67
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature] LICENSE NO.: E347
FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 28 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5381
Local Reg. No. 405
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JAN 23 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) Greenview Chalet

3. NAME OF DECEASED (Type or Print)
a. (First) GENTARO
b. (Middle)
c. (Last) TOMITA

4. DATE OF DEATH (Month) (Day) (Year) Dec. 15, 1967

5. SEX male
6. COLOR OR RACE Japanese
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2
8. DATE OF BIRTH 6 June 1881
9. AGE (In years last birthday) 86 — IF UNDER 1 YEAR Months 5 Days 9 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Japan
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Unknown — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Alfred Tomita — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

332X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11 June, 1966, *to* 12/15, 1967, *that I last saw the deceased alive on* 12/15, 1967, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE L. K. Frantz Jr. 294 (Degree or title)
23b. ADDRESS 798 S. Blue Shoe Falls
23c. DATE SIGNED 1/12/68

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem & Burial 3
24b. DATE 18, Dec. 1967
24c. NAME OF CEMETERY OR CREMATORY City Cemetery
24d. LOCATION (City, town, or county) (State) Salt Lake City, Utah

DATE REC'D BY LOCAL REG. Jan. 26-68
REGISTRAR'S SIGNATURE Anna Bridges
25. EMBALMER Leo A. Williams — LICENSE NO. E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

AUG 3 1978

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 22 1979

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5382
Local Reg. No. 379
Reg. Dist. No. 670

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY IN (this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 142 Idaho Avenue

3. NAME OF DECEASED (Type or Print): a. (First) PIERRE b. (Middle) BIDONDO c. (Last) AMESTOY

4. DATE OF DEATH (Month) (Day) (Year): Dec. 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Mar. 2, 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Ranching	Aldudes France	France

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Gratien Amestoy	France	Geanna Bidondo	France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	557-22-4742A	Madeline Amestoy	Rigby, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 5 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June 1965 *to* Dec 16, 1967, *that I last saw the deceased alive on* Dec 16, 1967, *and that death occurred at* 1:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
521 Eldon Hall	M.D,	Rigby, Idaho.	12/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 18, 1967	Pioneer	Rigby Jefferson Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 21-67	Emma Bundy	Bruce A. Eckersell	E 404

Federal Security Agency
United States Public Health Service

Form DH-6302

FIRM NAME: Eckersell Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5383
Local Reg. No. 395
Reg. Dist. No. 610

BIRTH NO.

RECEIVED JAN 10 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 45yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
d. STREET ADDRESS (If rural, give location): 439 3rd St.

3. NAME OF DECEASED (Type or Print): a. (First) CHARLES b. (Middle) HARRY c. (Last) STONE

4. DATE OF DEATH (Month) (Day) (Year): Dec. 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 2 Wid.
8. DATE OF BIRTH: Feb. 16, 1893
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Service 08
10b. KIND OF BUSINESS OR INDUSTRY: Mail, retired
11. BIRTHPLACE (State or foreign country): Morrison, Illinois
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Carson Stone — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Elizabeth White — BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown): Yes (If yes, give war or dates of service): WW I 3
16. SOCIAL SECURITY NO.: 518 42 8502
17. INFORMANT'S OWN SIGNATURE: Mrs E. Harold Brewington — ADDRESS: Ida. Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Occlusion
DUE TO (c) A S H D

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wendell L. McEwen 390 MD
23b. ADDRESS: 12-29-67 Idaho Falls
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-22-67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 6 1968
REGISTRAR'S SIGNATURE: Anna E. Rudges
25. EMBALMER: Buck Sullivan
LICENSE NO.: E 387
FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: JAN 11 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5384
Local Reg. No. 394
Reg. Dist. No. 610

Certificate of Death

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF (in this place): 8mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
d. STREET ADDRESS (If rural, give location): 250 Cleveland St.

3. NAME OF DECEASED (Type or Print)
a. (First): LINDA
b. (Middle): ANN
c. (Last): JENSEN

4. DATE OF DEATH (Month) (Day) (Year): #Dec. 17, 1967

5. SEX: Female
6. COLOR OR RACE: Indian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: April 2, 67
9. AGE (In years last birthday): If under 1 year: Months 8, Days 15; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NOne 02
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Justin Jensen
BIRTHPLACE: Winslow, Ariz.
14. MOTHER'S MAIDEN NAME: Maria Elias
BIRTHPLACE: Larado, Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: Justin Jensen
ADDRESS: Idaho Falls, Ida 250 Cleveland St.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4917

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchopneumonia acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): terminal aspiration
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE: A. Mitchell M.D. 746 (Degree or title)
23b. ADDRESS: L.D.S. Hosp. Idaho Falls, Ida.
23c. DATE SIGNED: 1/2/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/20/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan 6-1968
REGISTRAR'S SIGNATURE: Anna Bridger
25. EMBALMER: Bill Sullivan
LICENSE NO.: E 387

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: BuckFuneral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: 6-67-3308

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5385
Local Reg. No. 376
Reg. Dist. No. 610

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

JAN 3 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 3-10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 10 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 100 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Iona
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): Robert
c. (Last): Steele

4. DATE OF DEATH (Month) (Day) (Year): December 17 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: August 15, 1892
9. AGE (In years last birthday): 75 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Inspector of Potatoes
10b. KIND OF BUSINESS OR INDUSTRY: 08 State of Idaho
11. BIRTHPLACE (State or foreign country): Iona, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William George Steele — BIRTHPLACE: England
14. MOTHER'S MAIDEN NAME: Ellen Proctor — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519 09 2732A
17. INFORMANT'S OWN SIGNATURE: Gordon R Steele — ADDRESS: Iona, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Arteriosclerotic Heart Disease with myocardial failure. — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Emphysema - severe. — Years
Carcinome prostate with metastasis to bone. — 3 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 7, 1954, *to* Dec. 17, 1967, *that I last saw the deceased alive on* Dec. 17, 1967 *and that death occurred at* 11:00P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G. W. Corbett, M.D. — 104
23b. ADDRESS: 798 South Blvd. Idaho Falls, Idaho
23c. DATE SIGNED: Dec. 27, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/20/67
24c. NAME OF CEMETERY OR CREMATORY: Iona Cemetery
24d. LOCATION (City, town, or county) (State): Iona Bonneville County Idaho

DATE REC'D BY LOCAL REG.: Dec 28-67
REGISTRAR'S SIGNATURE: Anna Bredger
25. EMBALMER: Ralph M. Wood — LICENSE NO.: 413

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Wood Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5386
Local Reg. No. 392
Reg. Dist. No. 616

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 JAN 2 1968 2-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 2 MO. 23 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Extended Care Unit 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 260 Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
d. STREET ADDRESS (If rural, give location): 135 West Fremont

3. NAME OF DECEASED (Type or Print): a. (First) Raymond b. (Middle) Clyde c. (Last) Smuin

4. DATE OF DEATH: (Month) December (Day) 18 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: October 11, 1901

9. AGE (In years last birthday): 66
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter & Formica Installer

10b. KIND OF BUSINESS OR INDUSTRY: Const. 21

11. BIRTHPLACE (State or foreign country): Rexburg, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Smuin
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Harriett Barker
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 560 30 8757A

17. INFORMANT'S OWN SIGNATURE: Hazel Smuin
ADDRESS: Rigby, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 163X Carcinoma lung metastatic — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-20, 1967, *to* 12-18, 1967, *that I last saw the deceased alive on* 12-17, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 546 (Degree or title)

23b. ADDRESS: Idaho Falls Ida

23c. DATE SIGNED: 12/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/20/67

24c. NAME OF CEMETERY OR CREMATORY: Cedar Butte Cemetery

24d. LOCATION (City, town, or county) (State): Jefferson County Idaho

DATE REC'D BY LOCAL REG.: Dec. 23-67

REGISTRAR'S SIGNATURE: Anna Rudges

25. EMBALMER: Ralph M. Wood [signature]

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 2 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 11 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 7 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5387
Local Reg. No. 383
Reg. Dist. No. 6-16

BIRTH NO.

1. PLACE OF DEATH — JAN 2 1968

a. COUNTY: Bonneville 101 2-01

Bureau of Vital Statistics

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

c. LENGTH OF STAY (in this place): 27 days

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: 101 Bonneville

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls

d. STREET ADDRESS (If rural, give location): 520 North Water Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Mary b. (Middle) Catherine c. (Last) Turnbull

4. DATE OF DEATH (Month) (Day) (Year): December 18 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: January 25, 1885

9. AGE (In years last birthday): 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Townsend, Montana

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Michael Francis Sullivan — BIRTHPLACE: USA

14. MOTHER'S MAIDEN NAME: Mary Francis Neville — BIRTHPLACE: USA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 24 0569A

17. INFORMANT'S OWN SIGNATURE: William W. Turnbull — ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: 4 yrs

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Fracture, hip, postoperative Recent

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-23, 1967, *to* 12-18, 1967, *that I last saw the deceased alive on* 12-18, 1967 *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 5-46

23b. ADDRESS: Idaho Falls, Ida

23c. DATE SIGNED: 12/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/20/67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Dec. 23-67

REGISTRAR'S SIGNATURE: Emma Budge

25. EMBALMER: Ralph M. Wood — LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 4 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5388
Local Reg. No. 387
Reg. Dist. No. 610

RECEIVED JAN 3 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 1-08
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Idaho Falls
LENGTH OF STAY (in this place) 8 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 1510 Stanger Dr Live 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location) 1510 Stanger Dr.

3. NAME OF DECEASED (Type or Print) a. (First) FRANCIS b. (Middle) JOSEPH c. (Last) CALLAGHAN

4. DATE OF DEATH (Month) (Day) (Year) December 19, 1967

5. SEX Male
6. COLOR OR RACE Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single
8. DATE OF BIRTH June 4, 1946
9. AGE (In years last birthday) 21 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Military 05
10b. KIND OF BUSINESS OR INDUSTRY U.S. Army
11. BIRTHPLACE (State or foreign country) Denver, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE Daniel Patrick Callaghan, Denver, Colo
14. MOTHER'S MAIDEN NAME BIRTHPLACE Mary Agnes Byrne, Denver, Colo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Active Duty 1967
16. SOCIAL SECURITY NO. 519-52-8839
17. INFORMANT'S OWN SIGNATURE Daniel P Callaghan ADDRESS Ida. Falls, Ida. 1510 Stanger Dr.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) LACERATIONS AND INTRACEREBRAL HEMORRHAGE TO BRAIN STEM AND PONS TO RIGHT OF MIDLINE — INTERVAL BETWEEN ONSET AND DEATH: INSTANT

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) GUNSHOT WOUND, 22 CALIBER TO THROAT AND BASE OF SKULL, SELF-INFLICTED (SUICIDE)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. BLOOD ALCOHOL 2.52 MG/CC

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify) SUICIDE 9
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 00
21c. (CITY, TOWN, OR TOWNSHIP) IDAHO FALLS (COUNTY) 101 BONNEVILLE (STATE) IDAHO 13
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 583 HAZEL L. MC CAFFEY, M. D. (Degree or title) CORONER 4
23b. ADDRESS 2525 SOUTH BOULEVARD AVE, I.F.
23c. DATE SIGNED 12/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/22/67
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. Dec 29-67
REGISTRAR'S SIGNATURE Emma Burgess
25. EMBALMER Rece Sullivan
LICENSE NO. E 387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 18 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5389
Local Reg. No. 376
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 403 Maple St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 403 Maple St.

3. NAME OF DECEASED (Type or Print): a. (First) Ruby; b. (Middle) Page; c. (Last) Hecker

4. DATE OF DEATH (Month) (Day) (Year): Dec. 19, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 15 Jan 1888

9. AGE (In years last birthday): 79
IF UNDER 1 YEAR: Months 11; Days 4
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: O

11. BIRTHPLACE (State or foreign country): Austin, Minnesota

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Louis H. Page — BIRTHPLACE: Malden, Iowa

14. MOTHER'S MAIDEN NAME: Carrie Belle Armstrong — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Ethel a Sampsman — ADDRESS: Shell Wyo.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Thrombosis
DUE TO (c) Hypertensive Cardiovascular disease 10 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan., 1965, *to* Dec 19, 1967, *that I last saw the deceased alive on* Dec 16, 1967, *and that death occurred at* 7:10 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Bryant Weeks M.D.
23b. ADDRESS: 1585 So. Boulevard, Idaho Falls
23c. DATE SIGNED: 1-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 29 Dec. 1967
24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan 6 '68
REGISTRAR'S SIGNATURE: Anna Rudgin
25. EMBALMER: Leo A Williams
LICENSE NO.: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-6302

APR 4 1974

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5390
Local Reg. No. 398
Reg. Dist. No. 610

RECEIVED JAN 10 1968 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answer as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Star Route Box # 8

3. NAME OF DECEASED (Type or Print): a. (First) Jesse b. (Middle) LeRoy c. (Last) Hill

4. DATE OF DEATH: (Month) (Day) (Year) December 20 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: September 12, 1911

9. AGE (In years last birthday): 56
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Pipe Fitter & Plumber 21

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Idaho Falls, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Tillman Leonard Hill
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Phidella Labrum
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518 05 9223

17. INFORMANT'S OWN SIGNATURE: Nello Von Hill
ADDRESS: Idaho Falls, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4398

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Bacterial Endocarditis — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Staph Aureus coag positive
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Aortic stenosis — unknown

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/20, 1967, *to* 12/20, 1967, *that I last saw the deceased alive on* 12/20/67, 19___, *and that death occurred at* 9:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: L. T. Francis 294
(Degree or title): MD
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 1/4/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/23/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 4 1968
REGISTRAR'S SIGNATURE: Anna Rudges

25. EMBALMER: Ralph M. Wood Ralph M. Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 11 1963

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5391
Local Reg. No. 402
Reg. Dist. No. 610

RECEIVED JAN 16 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 17 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latter Day Saints Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): Route # 5 Box 373 A

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): William
c. (Last): Neibaur

4. DATE OF DEATH (Month) (Day) (Year): December 21 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: December 7, 1903
9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 06
10b. KIND OF BUSINESS OR INDUSTRY: Processing Plant
11. BIRTHPLACE (State or foreign country): Sharon, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Hyrum Adolph Neibaur — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Alice Ann Millward — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 14 3584
17. INFORMANT'S OWN SIGNATURE: Clyde W. Neibaur — ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

5501

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pulmonary Embolism — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Perforated appendix c̄ peritonitis post operative — 17 days
DUE TO (c): Stress ulcer c̄ hemorrhage — 2 days

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Emphysema Severe

19a. DATE OF OPERATION: Dec 4 - Dec 12
19b. MAJOR FINDINGS OF OPERATION: Perforated appendix c̄ generalized peritonitis Obstruction Smoke Home
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 12, 1958, *to* Dec. 21, 1967, *that I last saw the deceased alive on* Dec. 21, 1967, *and that death occurred at* 7:35 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): G W Corbett 104 G. W. Corbett, M.D.
23b. ADDRESS: 798 South Blvd.
23c. DATE SIGNED: 1/9/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/27/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Jan 10 - 1968
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Ralph M. Wood Ralph M Wood
LICENSE NO.: 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 17 1968

JAN 18 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 28 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5392
Local Reg. No. 377
Reg. Dist. No. 610

RECEIVED

BIRTH NO.

1. PLACE OF DEATH 101
a. COUNTY Bonneville JAN 10 1968 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls Bureau of Vital Statistics
c. LENGTH OF STAY IN (this place) 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 260
b. COUNTY Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Menan
d. STREET ADDRESS (If rural, give location) X

3. NAME OF DECEASED (Type or Print) a. (First) KENNETH b. (Middle) FOREST c. (Last) WILSON

4. DATE OF DEATH (Month) (Day) (Year) December 23, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH December 19, 1907

9. AGE (In years last birthday) 60 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Peace officer 08

10b. KIND OF BUSINESS OR INDUSTRY Police

11. BIRTHPLACE (State or foreign country) Oakland, Illinois

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Andrew J. Wilson. BIRTHPLACE Salem, Indiana

14. MOTHER'S MAIDEN NAME Bertha Viola Swinford. BIRTHPLACE Oakland, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

(If yes, give war or dates of service) X

16. SOCIAL SECURITY NO. 519-05-4369

17. INFORMANT'S OWN SIGNATURE Dorothy Wilson ADDRESS Menan, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 hour

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-11, 1943 *to* Dec 23, 1967, *that I last saw the deceased alive on* Dec. 23, 1967, *and that death occurred at* 10:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Asael Hall, 522 (Degree or title) M.D.

23b. ADDRESS Rigby, Idaho.

23c. DATE SIGNED 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 26, 1967

24c. NAME OF CEMETERY OR CREMATORY Little Butte

24d. LOCATION (City, town, or county) (State) Annis Jefferson Idaho

DATE REC'D BY LOCAL REG. Jan 2 '68

REGISTRAR'S SIGNATURE Anne Bridges

25. EMBALMER Bruce A. Eckersell Bruce A. Eckersell LICENSE NO. E404

FIRM NAME: Eckersell Memorial Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: FEB 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5343
Local Reg. No. 393
Reg. Dist. No. 611

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Route # 5

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 450 West 15th Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Iris		Jensen	December 23 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	April 29, 1904	63				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Clifton, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Steven Hogan — BIRTHPLACE: Florida
14. MOTHER'S MAIDEN NAME: Mary Laura Bell — BIRTHPLACE: Alabama

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 548 22 7655
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: Idaho Falls, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4420X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardio-Renal sclerosis — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept., 1967, *to* Dec 23, 1967, *that I last saw the deceased alive on* Dec. 21, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): T. C. Erickson M.D.
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: 12-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/27/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Jan. 4 1968
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Ralph M. Wood [signature]
LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5394
Local Reg. No. 397
Reg. Dist. No. 610

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 10 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (If outside place): 4days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): LDS Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls,
d. STREET ADDRESS (If rural, give location): 840 E Elva

3. NAME OF DECEASED (Type or Print)
a. (First): EDWARD
b. (Middle): *
c. (Last): GURULE

4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1967

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Single
8. DATE OF BIRTH: Oct. 17, 1877
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheepherder 04
10b. KIND OF BUSINESS OR INDUSTRY: Ranch
11. BIRTHPLACE (State or foreign country): Unknown
12. CITIZEN OF WHAT COUNTRY?: Unk.

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Unknown — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 20 3266 A
17. INFORMANT'S OWN SIGNATURE: D.P.A. Records [signature] — ADDRESS: Idaho Falls, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

493X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Terminal pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Senile Changes — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harvey A Hatch M.D. 208
23b. ADDRESS: Idaho Falls, Idaho
23c. DATE SIGNED: Dec. 29, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/27/67
24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 6-68
REGISTRAR'S SIGNATURE: Anna Budges
25. EMBALMER: Bill Sullivan
LICENSE NO.: E387

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Buck Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5395
Local Reg. No. 373
Reg. Dist. No. 610

Certificate of Death

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 101 Bonneville 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
c. LENGTH OF ISLAND (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 101
b. COUNTY Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
d. STREET ADDRESS (If rural, give location) 477 West 17th Street

3. NAME OF DECEASED (Type or Print)
a. (First) Francis
b. (Middle) Burl
c. (Last) Street

4. DATE OF DEATH (Month) December (Day) 24 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH August 7, 1906
9. AGE (In years last birthday) 61 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plumber 11
10b. KIND OF BUSINESS OR INDUSTRY Construction
11. BIRTHPLACE (State or foreign country) Upton, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Alexander Street — BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Sarah Clark — BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW 11 4
16. SOCIAL SECURITY NO. 518 05 8450
17. INFORMANT'S OWN SIGNATURE Mrs Ivy Street — ADDRESS Idaho Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetic Acidosis — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Diabetes mellitus — Inv.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Arteriosclerotic Heart Disease Years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-5, 1959, *to* 12/24, 1967, *that I last saw the deceased alive on* 12/24, 1967 *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 546 (Degree or title) MD
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 12/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/27/67
24c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery
24d. LOCATION (City, town, or county) Idaho Falls (State) Idaho

DATE REC'D BY LOCAL REG. Jan 4-1968
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Ralph M. Wood [signature] — LICENSE NO. 413
FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 1 1 1968 JAN 12 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25. FEB 1 1968 MAR 19 1968 AUG 23 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5396
Local Reg. No. 379
Reg. Dist. No. 610

STATE OF IDAHO

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
JAN 10 1968

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 — 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place): 1mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sacred Heart Hospital 043

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): 525 Holbrook

3. NAME OF DECEASED (Type or Print): a. (First) MARTHA b. (Middle) LOUISE c. (Last) HELBIG

4. DATE OF DEATH (Month) (Day) (Year): Dec. 26, 1967

5. SEX: Female

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 2 Widowed

8. DATE OF BIRTH: Feb. 26, 1886

9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: HOme

11. BIRTHPLACE (State or foreign country): Thalheim, Germany

12. CITIZEN OF WHAT COUNTRY?: Germany

13. FATHER'S NAME: August Roscher — BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Wilhelmina Griesbach — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 157 38 7111

17. INFORMANT'S OWN SIGNATURE: Martha Hahn — ADDRESS: 525 Holbrook, Id

18. CAUSE OF DEATH — MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease (Years) — INTERVAL BETWEEN ONSET AND DEATH: 4200

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Postoperative amputation for thrombosis of popliteal art. — Acute

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-[illegible], 1967, *to* 12/26, 1967, *that I last saw the deceased alive on* 12/26, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 546 (Degree or title)

23b. ADDRESS: Idaho Falls Ida

23c. DATE SIGNED: 12/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/28/67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 1-1968

REGISTRAR'S SIGNATURE: Anna Rodgers

25. EMBALMER: [signature]

LICENSE NO.: E387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 1 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Nielsen

Certificate of Death

STATE OF IDAHO

State File No. 5397
Local Reg. No. 399
Reg. Dist. No. 610

BIRTH NO.

RECEIVED JAN 10 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville 10 OOC
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 10 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): LDS Rest Home

3. NAME OF DECEASED (Type or Print): a. (First) Lola b. (Middle) Miller c. (Last) Nielsen Hampton

4. DATE OF DEATH: (Month) (Day) (Year): Dec, 28, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 18 Nov 1882

9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months 1, Days 10 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Elsinore Utah

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charles Miller — BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Isabelle Thurston — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Carol Neilson — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Occlusion
DUE TO (c) A S H D

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Hypertension

4201

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Wendell L McEwen MD 390 (Degree or title) — **23b. ADDRESS**: Idaho Falls — **23c. DATE SIGNED**: 1-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Jan 2, 1968

24c. NAME OF CEMETERY OR CREMATORY: Taylor Cemetery

24d. LOCATION (City, town, or county) (State): Taylor, Idaho

DATE REC'D BY LOCAL REG.: Jan. 6-68

REGISTRAR'S SIGNATURE: Emma Bridges

25. EMBALMER: Geo A Williams — **LICENSE NO.**: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Amended

RECEIVED FEB 13 1968

Certificate of Death

STATE OF IDAHO

State File No. 5398
Local Reg. No. 403
Reg. Dist. No. 610

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
Bur. of Vital Statistics
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 673 Kelsey

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 673 Kelsey

3. NAME OF DECEASED (Type or Print)
a. (First): Lurlie
b. (Middle): Clifton
c. (Last): Hjort

4. DATE OF DEATH: (Month) (Day) (Year): Dec 27, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: 30 Aug 1908

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR: Months: 4 Days: 28
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): White Cloud, Kansas

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Clifton
BIRTHPLACE: Tenn.

14. MOTHER'S MAIDEN NAME: ? Law
BIRTHPLACE: ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Van T Hjort
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary Heart disease — days
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 22 Dec, 1967, *to* 27 Dec, 1967, *that I last saw the deceased alive on* 27 Dec, 1967, *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph M Hatch MD
23b. ADDRESS: Idaho Falls Ida
23c. DATE SIGNED: 7 Feb 1968

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 30 Dec, 1967
24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.:
REGISTRAR'S SIGNATURE: Anna Bridges
25. EMBALMER: Leo A Williams
LICENSE NO.: E-319

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Williams Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5398
Local Reg. No. 403
Req. Dist. No. 610

BIRTH NO.

RECEIVED JAN 16 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Bonneville 101 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 673 Kelsey 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 673 Kelsey

3. NAME OF DECEASED (Type or Print): a. (First) Lurlie b. (Middle) Clifton c. (Last) Hjort

4. DATE OF DEATH (Month) (Day) (Year): Dec. 28, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: 30 Aug 1908

9. AGE (In years last birthday): 59 IF UNDER 1 YEAR Months: 4 Days: 28 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): White Cloud, Kansas

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: James Clifton
BIRTHPLACE: Tenn.

14. MOTHER'S MAIDEN NAME: ?
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Dan T Hjort
ADDRESS: Idaho Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 4281

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June 12, 1946 *to* 28 Dec, 1967, *that I last saw the deceased alive on* 27 Dec, 1967, *and that death occurred at* 3:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph M Natale MD

23b. ADDRESS: Idaho Falls Idaho

23c. DATE SIGNED: 2 Jan 68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 30 Dec. 1967

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan 11-1968

REGISTRAR'S SIGNATURE: Anna Bridges

25. EMBALMER: Leo A Williams

LICENSE NO.: E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 26 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5399
Local Reg. No. 464
Reg. Dist. No. 6 10

RECEIVED JAN 16 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls,
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L. D. S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 060 Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Shelley,
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Matilda b. (Middle) Ellen c. (Last) Pixton

4. DATE OF DEATH (Month) Dec (Day) 31 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH Jan 8 1883

9. AGE (In years last birthday) 85 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Salt Lake City, Utah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Charles Mormon Nokes BIRTHPLACE Brighton, Iowa

14. MOTHER'S MAIDEN NAME Caroline Matilda Hamilton BIRTHPLACE St Joseph Mo.,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-28-8096

17. INFORMANT'S OWN SIGNATURE Wayne W. Pixton ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) [illegible]

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) [illegible]
DUE TO (c) [illegible]

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP). (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible], 19[illegible], *to* 12-27, 1967, *that I last saw the deceased alive on* 12-27, 1967, *and that death occurred at* 10:10 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE [illegible] 418 (Degree or title) Vital

23b. ADDRESS Shelley Idaho

23c. DATE SIGNED 1/5/68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 1/3/68

24c. NAME OF CEMETERY OR CREMATORY Grove City Cemetery

24d. LOCATION (City, town, or county) Blackfoot Bingham (State) Idaho

DATE REC'D BY LOCAL REG. Jan. 10-68

REGISTRAR'S SIGNATURE Anna Budge

25. EMBALMER Floyd M Nalder LICENSE NO. E 275

FIRM NAME: Nalder Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5400
Local Reg. No. 466
Reg. Dist. No. 610

RECEIVED JAN 16 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Bonneville 101 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Idaho Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) L.D.S. Hospital 042

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Tacoma
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Frances b. (Middle) Hornbuckle c. (Last) Kinney Usselman
4. DATE OF DEATH (Month) (Day) (Year) Dec. 31, 1967
5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 2 widowed
8. DATE OF BIRTH 9 Sept 1900
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months 3 Days 22 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Inola, Oklahoma
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Louis J. Hornbuckle BIRTHPLACE ?
14. MOTHER'S MAIDEN NAME Lucinda ? BIRTHPLACE Oklahoma
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Joseph L. Kinney ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH 6 mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

~~DUE TO (c)~~ Pneumonia

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Myocardial aneurysm

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept., 1967, *to* Dec 31, 1967, *that I last saw the deceased alive on* Dec 30, 1967, *and that death occurred at* 3:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE 556 (Degree or title) Bryant Weeks M.D.
23b. ADDRESS 1585 So. Boulevard.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 2 Jan-1968
24c. NAME OF CEMETERY OR CREMATORY Mt. View Memorial Park
24d. LOCATION (City, town, or county) Tacoma, Washington (State)

DATE REC'D BY LOCAL REG. Jan-1968
REGISTRAR'S SIGNATURE Lena Rudger
25. EMBALMER Geo A. Williams
LICENSE NO. E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-6302

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 17 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5401
Local Reg. No. 59-67
Reg. Dist. No. 100

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Boundary 110 2-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 6¼ months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boundary County Nursing Home 341

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry 110
d. STREET ADDRESS (If rural, give location): Star Route #2

3. NAME OF DECEASED (Type or Print)
a. (First): NELLE
b. (Middle): ANGUISH
c. (Last): BOGUE

4. DATE OF DEATH (Month) (Day) (Year): December 3, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 8, 1877
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Homemaking
11. BIRTHPLACE (State or foreign country): Clinton, Iowa
12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Benjamin C. Bogue — BIRTHPLACE: Chitenango, New York
14. MOTHER'S MAIDEN NAME: Luella Kerwin — BIRTHPLACE: Lockport, New York

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 365-34-3033
17. INFORMANT'S OWN SIGNATURE: Eunice B. Tanner — ADDRESS: Bonners Ferry Idaho

18. CAUSE OF DEATH 334X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Respiratory Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Prev. Stroke
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7, 1967, *to* 12/3, 1967, *that I last saw the deceased alive on* 12/3, 1967, *and that death occurred at* 7 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 153 (Degree or title) MD
23b. ADDRESS: Bonners Ferry Ida
23c. DATE SIGNED: 12/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation 2
24b. DATE: 12/5/67
24c. NAME OF CEMETERY OR CREMATORY: Hazen & Jaeger Crematory
24d. LOCATION (City, town, or county) (State): Spokane Washington

DATE REC'D BY LOCAL REG.: Dec. 9, 1967
REGISTRAR'S SIGNATURE: Virgila Stone
25. EMBALMER: Charles [signature]
LICENSE NO.: E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5402
Local Reg. No. 60-67
Reg. Dist. No. 100

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Boundary 110 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry
LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Highway #95, Enroute by Amb.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Bonners Ferry 110
d. STREET ADDRESS (If rural, give location) P. O. Box #312

3. NAME OF DECEASED (Type or Print) a. (First) HERMAN b. (Middle) PETER c. (Last) SINCLAIR

4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 6, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH August 9, 1913
9. AGE (In years last birthday) 54 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver 27
10b. KIND OF BUSINESS OR INDUSTRY Transportation
11. BIRTHPLACE (State or foreign country) Butte, Nebraska
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Peter Edward Sinclair BIRTHPLACE Pennsylvania
14. MOTHER'S MAIDEN NAME Maggie Pfeifer BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 518-16-8861
17. INFORMANT'S OWN SIGNATURE Mrs. Herman Sinclair ADDRESS Bonners Ferry Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 1 hr 50 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Massive head & facial lacerations
DUE TO (c) Massive contusion, left lung and kidney

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Multiple fractures left ribs, posteriorly and left transverse processes, lumbar vertebrae.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Great Northern R/R
21c. (CITY, TOWN, OR TOWNSHIP) Bonners Ferry (COUNTY) 110 Boundary (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12/6/67 10:30 A. m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Struck by railroad train pushing crane truck.

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY, 19—, *that I last saw the deceased alive on* December 6 1967, *and that death occurred at* 12:20P m., *from the causes and on the date stated above.*

23a. SIGNATURE C. M. Callahan 583 (Degree or title) Coroner 4
23b. ADDRESS Bonners Ferry, Idaho
23c. DATE SIGNED 12/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/9/67
24c. NAME OF CEMETERY OR CREMATORY Grandview Cemetery
24d. LOCATION (City, town, or county) Bonners Ferry (State) Idaho

DATE REC'D BY LOCAL REG. 12/11/67
REGISTRAR'S SIGNATURE Twyla Stone
25. EMBALMER
LICENSE NO. E-453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED
JAN 15 1968
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 5403
Local Reg. No. 63-67
Reg. Dist. No. 100

BIRTH NO.

1. PLACE OF DEATH 110
a. COUNTY: Boundary 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry
c. LENGTH OF STAY (in this place): 42 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Community Hospital 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boundary
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Bonners Ferry 110
d. STREET ADDRESS (If rural, give location): P O Box 656

3. NAME OF DECEASED (Type or Print)
a. (First): Hyrstal
b. (Middle): Ruben
c. (Last): Tompkins

4. DATE OF DEATH (Month) (Day) (Year): Dec. 27 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: April 15, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Seattle, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Edwin Tompkins — BIRTHPLACE: Peeksville, N. Y.
14. MOTHER'S MAIDEN NAME: Elizabeth Curnow — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518-05-4973A
17. INFORMANT'S OWN SIGNATURE: Mrs Lee Galbraith — ADDRESS: Daughter

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1621

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchiogenic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 2 Mo.

ANTECEDENT CAUSES — Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19__, to 12/27, 1967, that I last saw the deceased alive on 12/27, 1967, and that death occurred at 8 P m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 153 (Degree or title): M D
23b. ADDRESS: Bonners Ferry, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-30-67
24c. NAME OF CEMETERY OR CREMATORY: Grandview
24d. LOCATION (City, town, or county) (State): Boundary County, Idaho

DATE REC'D BY LOCAL REG.: Jan. 12, 1968
REGISTRAR'S SIGNATURE: Tivyla Stone
25. EMBALMER: [signature]
LICENSE NO.: E 453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hillcrest Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5404
Local Reg. No. 62-67
Reg. Dist. No. 100

BIRTH NO.

JAN 15 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: BOUNDARY 110 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BONNERS FERRY
c. LENGTH OF STAY (In this place): 2 mths
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): COMMUNITY HOSPITAL 047

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: MONTANA 27
b. COUNTY: Lewis & Clark 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): HELENA
d. STREET ADDRESS (If rural, give location): 1221 HUDSON

3. NAME OF DECEASED (Type or Print)
a. (First): LE ROY
b. (Middle): ALFRED
c. (Last): DICKINSON

4. DATE OF DEATH (Month) 12 (Day) 30 (Year) 1967

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): DIVORCED 4
8. DATE OF BIRTH: 12-25-1889
9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BOILER FIREMAN 08
10b. KIND OF BUSINESS OR INDUSTRY: U S GOVT.
11. BIRTHPLACE (State or foreign country): BRECKENRIDGE, MINNESOTA
12. CITIZEN OF WHAT COUNTRY?: U S A

13. FATHER'S NAME: EDWARD DICKINSON — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: CLARA FRANKS — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 517-09-3933
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: 1221 Hudson, Helena, Mont.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1530

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): peritonitis — 2 wks
DUE TO (c): Bowell obstruction — 2 wks

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: ASHD — unkn

19a. DATE OF OPERATION: 12/19/67
19b. MAJOR FINDINGS OF OPERATION: Invasive Carcinoma Cecum
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/18, 1967, *to* 12/30, 1967, *that I last saw the deceased alive on* 12/30, 1967, *and that death occurred at* 9 *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 103 (Degree or title): M D
23b. ADDRESS: BONNERS FERRY, IDAHO
23c. DATE SIGNED: 1/9/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-2-1968
24c. NAME OF CEMETERY OR CREMATORY: POST FALLS CEMETERY
24d. LOCATION (City, town, or county) (State): POST FALLS, KOOTENAI IDAHO

DATE REC'D BY LOCAL REG.: 1-11-68
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E 453

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: HILLCREST MEMORIAL CHAPEL

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 16 1968 JAN 25 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5405
Local Reg. No. 11
Reg. Dist. No. 670

BIRTH NO.

RECEIVED DEC 26 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 120 Butte 401
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco
c. LENGTH OF STAY (in this place) 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 13
b. COUNTY Butte
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco 120
d. STREET ADDRESS (If rural, give location) 237 Arco Ave.

3. NAME OF DECEASED (Type or Print) a. (First) SIDNEY b. (Middle) L. c. (Last) MILLER

4. DATE OF DEATH (Month) (Day) (Year) December 4, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH June 3, 1915

9. AGE (In years last birthday) 52 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steam Fitter 11

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Velma, Oklahoma

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Daniel R. Miller BIRTHPLACE N. Carolina

14. MOTHER'S MAIDEN NAME Hattie Grahm BIRTHPLACE Tussie, Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W. W. II 4

16. SOCIAL SECURITY NO. 447-26-9441

17. INFORMANT'S OWN SIGNATURE X Birdie Lee Miller ADDRESS Arco, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 1½ hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-4-, 1967, *to* 12-4, 1967, *that I last saw the deceased alive on* 12-4, 1967, *and that death occurred at* 9:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE R. Bowden M.D. (Degree or title) 031

23b. ADDRESS Arco, Ida

23c. DATE SIGNED 12-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. Burial

24b. DATE 12-6-67

24c. NAME OF CEMETERY OR CREMATORY Velma Cemetery

24d. LOCATION (City, town, or county) (State) Velma, Oklahoma

DATE REC'D BY LOCAL REG. Dec 12-1967

REGISTRAR'S SIGNATURE Betty J. Marvel

25. EMBALMER C. W. Marvel

LICENSE NO. E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 13 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5406
Local Reg. No. 12
Reg. Dist. No. 670

BIRTH NO. DEC 26 1967

1. PLACE OF DEATH 120
a. COUNTY Butte Bureau of Vital Statistics 3-21
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco
c. LENGTH OF STAY (in this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lost Rivers Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Custer
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 190 Rural-Mackay
d. STREET ADDRESS (If rural, give location) 11 Miles North of Mackay

3. NAME OF DECEASED (Type or Print)
a. (First) CONRAD
b. (Middle) EARNEST
c. (Last) WRIEDT

4. DATE OF DEATH (Month) (Day) (Year) December 10, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Jan. 26, 1896
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ranch Laborer 04
10b. KIND OF BUSINESS OR INDUSTRY Laborer
11. BIRTHPLACE (State or foreign country) Germany
12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME BIRTHPLACE Unobtainable
14. MOTHER'S MAIDEN NAME BIRTHPLACE Unobtainable

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-48-2908
17. INFORMANT'S OWN SIGNATURE X Tommy C. Pineal — ADDRESS Mackay, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerotic heart disease — 10 yrs
~~DUE TO~~ (c) Anemia Severe — ? 3 wks

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Chest injury - Cracked Ribs — 3 wks

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov. 19, 1967, *to* Dec. 10, 1967, *that I last saw the deceased alive on* Dec 10, 1967, *and that death occurred at* 11:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE R. Barker 031 (Degree or title)
23b. ADDRESS Arco
23c. DATE SIGNED 12-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-14-67
24c. NAME OF CEMETERY OR CREMATORY Mt. McCaleb
24d. LOCATION (City, town, or county) (State) Mackay, Idaho

DATE REC'D BY LOCAL REG. Dec. 20-1967
REGISTRAR'S SIGNATURE Betty J. Marvel
25. EMBALMER E. H. Marvel
LICENSE NO. E-457

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Marvel Memorial Chapel, Arco

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 29 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 20 1967

Certificate of Death

STATE OF IDAHO

State File No. 5407
Local Reg. No. 13
Reg. Dist. No. 670

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Butte 120 Bur "
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Lost Rivers Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Butte
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arco 120
d. STREET ADDRESS (If rural, give location) 350 W. Grand Ave

3. NAME OF DECEASED (Type or Print) a. (First) MARK b. (Middle) 000 c. (Last) HANNA

4. DATE OF DEATH (Month) (Day) (Year) December 13, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widower 2
8. DATE OF BIRTH Nov. 17, 1894
9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rancher 04
10b. KIND OF BUSINESS OR INDUSTRY Ranching
11. BIRTHPLACE (State or foreign country) Arco, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Hanna BIRTHPLACE Ireland
14. MOTHER'S MAIDEN NAME Mary Jane Beverland BIRTHPLACE Utah Salt Lake City,

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-42-9698
17. INFORMANT'S OWN SIGNATURE X Mary Jean H. Denning ADDRESS Las Vegas, Nevada

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION 8254

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Multiple fractures and contusion of chest — INTERVAL BETWEEN ONSET AND DEATH: 15 mins.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Possible fracture of cervical vertebrae
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway 06
21c. (CITY, TOWN, OR TOWNSHIP) Moore 13 (COUNTY) Butte 120 (STATE) Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 13, 1967 6:15 pm
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Automobile Accident

22. I hereby certify that I attended the deceased from Attended as Coroner Only, 19___, to ___, 19___, that I last saw the deceased alive on ___, 19___, and that death occurred at 6:30p m., from the causes and on the date stated above.

23a. SIGNATURE C. W. Marvel 583 (Degree or title) Butte Co. Coroner 4
23b. ADDRESS Arco, Idaho
23c. DATE SIGNED 12-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-16-67
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State) Arco, Idaho

DATE REC'D BY LOCAL REG. Dec. 20-1967
REGISTRAR'S SIGNATURE Betty J. Marvel
25. EMBALMER C. W. Marvel
LICENSE NO. E-457
FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JUN 20 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5408
Local Reg. No. 1
Reg. Dist. No. 670

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 120 Butte — JAN 18 1968 — 2-08
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Howe — Burial
c. LENGTH OF STAY (in this place) 8 mos
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 20 Miles N.E.of Howe 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Butte
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural-Howe — 120
d. STREET ADDRESS (If rural, give location) 5 miles East of Howe

3. NAME OF DECEASED (Type or Print) a. (First) MICHAEL b. (Middle) D. c. (Last) HERLIHY

4. DATE OF DEATH (Month) (Day) (Year) December 18, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Single

8. DATE OF BIRTH Dec. 14, 1902

9. AGE (In years last birthday) 65 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ranch laborer 04

10b. KIND OF BUSINESS OR INDUSTRY Ranching

11. BIRTHPLACE (State or foreign country) Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Daniel Herlihy — BIRTHPLACE Ireland

14. MOTHER'S MAIDEN NAME Not Known — BIRTHPLACE Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) W.W. II

16. SOCIAL SECURITY NO. 568-42-6236

17. INFORMANT'S OWN SIGNATURE Jerry Callaghan — ADDRESS Bellingham, Wash.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Artery Disease
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* As Coroner Only-Did Not See Alive, 19__, *to* __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* 6:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE C. H. Marvel — 583 (Degree or title) Butte Co. Coroner

23b. ADDRESS Arco, Idaho

23c. DATE SIGNED 1-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 1/6/1968

24c. NAME OF CEMETERY OR CREMATORY Sunset Park Cemetery

24d. LOCATION (City, town, or county) (State) Lakeview, Oregon

DATE REC'D BY LOCAL REG. Jan 15 1968

REGISTRAR'S SIGNATURE Betty J. Marvel

25. EMBALMER C. H. Marvel — LICENSE NO. E-457

FIRM NAME: Marvel Memorial Chapel, Arco

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 19 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5409
Local Reg. No. 14
Reg. Dist. No. 670

RECEIVED DEC 26 1967

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Butte 120
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Arco
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Arco Hospital 264

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston 211
d. STREET ADDRESS (If rural, give location): 75 E. Valley View Drive

3. NAME OF DECEASED (Type or Print)
a. (First): Donald
b. (Middle): Reed
c. (Last): Robinson

4. DATE OF DEATH (Month) (Day) (Year): Dec 15, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: 7 July 1913
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Representative
10b. KIND OF BUSINESS OR INDUSTRY: 24 W.R.White Co.
11. BIRTHPLACE (State or foreign country): Franklin, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Louis Perly Robinson — BIRTHPLACE: Franklin, Ida.
14. MOTHER'S MAIDEN NAME: Lillie Jane Atkinson — BIRTHPLACE: Franklin, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 529-12-1004
17. INFORMANT'S OWN SIGNATURE: Ganza Robinson — ADDRESS: Preston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1-2 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 15, 1967, *to* Dec 15, 1967, *that I last saw the deceased alive on* Dec 15, 1967, *and that death occurred at* 8:45 p m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. Barker 031 (Degree or title)
23b. ADDRESS: Arco
23c. DATE SIGNED: 12-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Franklin Cemetery
24d. LOCATION (City, town, or county) (State): Franklin, Idaho

DATE REC'D BY LOCAL REG.: Dec. 20. 1967
REGISTRAR'S SIGNATURE: Betty J. Marvel
25. EMBALMER: C. H. Marvel
LICENSE NO.: E-457

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Marvel Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 3 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 4 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 26 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. Kearns —

Certificate of Death

STATE OF IDAHO

State File No. 5410
Local Reg. No.
Reg. Dist. No.

RECEIVED
DEC 18 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 130 Camas
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield
LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Camas
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield 130
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Grace	Burdette	Edwards	Dec.	8,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Feb. 2, 1893	74				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Murphysboro, Illinois	U.S.U.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Youngman	Illinois	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	none	518-36-80-6	X John L Edwards	Fairfield, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

360X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Atherosclerosis — years
DUE TO (c) Diabetes Mellitus — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 1960, *to* 8 Dec, 1967, *that I last saw the deceased alive on* 15 Nov, 1967, *and that death occurred at* 1:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marion D Kearns 279	MD	Fairfield Ida	14 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-12-1967	Elmwood Cemetery	Gooding, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
14 Dec. 1967	Estelle Taylor	Roberta S Meyer	E-424

FIRM NAME: Thompson Chapel-Gooding, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 4 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5411
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Camus 130
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Residence, No. West, Fairfield

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Camus
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairfield 130
d. STREET ADDRESS (If rural, give location): Rural No. &w. of City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
ATHAN	C. 000	TUFARES	Dec. 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed 2	Jan. 6, 1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Cafe owner 22	cafe	Athens, Greece	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unk	Greece	Maria U K	Greece

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	464-03-2348	Marie L Tucker	Fairfield, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cardiac Failure	1 day
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hypertensive Heart Disease	years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

443X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 26 Dec, 1967, *to* 26 Dec, 1967, *that I last saw the deceased alive on* 26 Dec, 1967, *and that death occurred at* 1:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Marion J Kerns 279 MD	Fairfield Idaho	27 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
removal 3	12/26/67	Albuquerque Cemetery	Albuquerque, New Mexico

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
	Estelle Vaught	Keith Bird Keith Bird	E-373

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bird Funeral Home, Hailey, Ida

DUTIES:

FEB 24 1998

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 05 1999

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 26 1967

State File No. 5412
Local Reg. No. 211
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Caldwell, Idaho
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Blakely Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho 141
d. STREET ADDRESS (If rural, give location) 2124 South Michigan

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	ADA	RUTH	GARLAND	11	21	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widowed 2	Feb 12, 1890	77	9.	9		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Self	Winslow, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Jones	Ky.	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	519-14-8133	Mrs Pauline Moore	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	C.V.S. cardio-vascular disease	years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Cerebral vascular sclerosis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb., 1962, *to* Oct., 1967, *that I last saw the deceased alive on* Oct. 3, 1967, *and that death occurred at* 11 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
K. Kellogg 275	1261 S Kimball Caldwell Idaho	18 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal	11/25/67	Cloverdale	Boise, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 22, 1967	Mrs. Martina Walmsley	Lucy M Flahiff	E 393

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Flahiff Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

7-6

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5413
Local Reg. No. 221
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142 DEC 27 1967 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 1 Year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Boulvard Nursing Home 284

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa 142
d. STREET ADDRESS (If rural, give location) 472 Nampa Blvd. c/o Boulvard Nursing Home

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) WILFORD
c. (Last) HOWARD

4. DATE OF DEATH (Month) 12 (Day) 1 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 1/19/1885
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 08
10b. KIND OF BUSINESS OR INDUSTRY Idaho Dept. Hiway
11. BIRTHPLACE (State or foreign country) Skemersdale, England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Howard — BIRTHPLACE England
14. MOTHER'S MAIDEN NAME Elizabeth Pendleton — BIRTHPLACE England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-05-8452
17. INFORMANT'S OWN SIGNATURE Leonard J. Howard — ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

177X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis from Prostate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aplastic Anemia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-3, 1967, *to* 12-1-, 1967, *that I last saw the deceased alive on* 11-30, 1967, *and that death occurred at* 4:30 pm., *from the causes and on the date stated above.*

23a. SIGNATURE Grayton O. Grant 115 (Degree or title)
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/4/1967
24c. NAME OF CEMETERY OR CREMATORY Carey Cemetery
24d. LOCATION (City, town, or county) (State) Carey, Idaho

DATE REC'D BY LOCAL REG. Dec. 26, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Conway Grant
LICENSE NO. E478

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: RELYEA MORTUARY

FEB 2 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5414
Local Reg. No. 197
Reg. Dist. No. 360

BIRTH NO.

RECEIVED DEC 7 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
c. LENGTH OF STAY 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 141 Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) 507 Freeport

3. NAME OF DECEASED (Type or Print) a. (First) PEARL b. (Middle) 051 ELIZABETH c. (Last) JESSEN

4. DATE OF DEATH (Month) 12 (Day) 1 (Year) 67

5. SEX F

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Feb 3, 1885

9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months 9 Days 28 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Self

11. BIRTHPLACE (State or foreign country) Winnebogo, Illinois

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE David Myers Erie, Penn.

14. MOTHER'S MAIDEN NAME BIRTHPLACE Martha Dawson Rockford, Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 519-22-6995

17. INFORMANT'S OWN SIGNATURE & ADDRESS X Laverla Jessen

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

237X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Brain Tumor — INTERVAL BETWEEN ONSET AND DEATH Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 40 yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1965 *to* 12-1, 1967, *that I last saw the deceased alive on* 12-1, 1967 *and that death occurred at* 5:30 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE & (Degree or title) 258 MD
23b. ADDRESS Robert H. Jensen, M.D. 222 EAST LOGAN
23c. DATE SIGNED DEC 5, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/5/67
24c. NAME OF CEMETERY OR CREMATORY Middleton
24d. LOCATION (City, town, or county) (State) CALDWELL, IDAHO Middleton, Idaho

DATE REC'D BY LOCAL REG. Dec. 6, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Jerry M Flahiff
LICENSE NO. E 393
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

APR 24 1996

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5415
Local Reg. No. 206
Reg. Dist. No. 360

RECEIVED
DEC 20 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Canyon — b. CITY OR TOWN: Nampa — c. LENGTH OF STAY IN (this place): 0-00 — d. FULL NAME OF HOSPITAL OR INSTITUTION: 935- 11 Avenue North 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Canyon — c. CITY OR TOWN: Nampa — d. STREET ADDRESS: 935- 11 Avenue North

3. NAME OF DECEASED (Type or Print) — a. (First): BESSIE — b. (Middle): IRMA — c. (Last): MOULTON

4. DATE OF DEATH — (Month): December — (Day): 2 — (Year): 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: January 2, 1888

9. AGE (In years last birthday): 79 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY: School Teaching

11. BIRTHPLACE (State or foreign country): Viroqua, Wisconsin

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry W. Dickson — BIRTHPLACE: No Record

14. MOTHER'S MAIDEN NAME: Caroline Jones — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no

17. INFORMANT'S OWN SIGNATURE: x Crystal D. Larson — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

4330

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Severe Ventricular Irritability

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

CEKG 10/24/67

19a. DATE OF OPERATION — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) — 21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) — 21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) — 21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — 21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 1967, *to* Dec 2, 1967, *that I last saw the deceased alive on* Dec 1, 1967, *and that death occurred at* 12 noon, *from the causes and on the date stated above.*

23a. SIGNATURE: J. K. Manyum MD — (Degree or title): 322 — 23b. ADDRESS: Nampa, Idaho — 23c. DATE SIGNED: 12/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 24b. DATE: 12/6/67 — 24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery — 24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1967 — REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: [signature] — LICENSE NO.: E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 20 1967

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5416
Local Reg. No. 199
Reg. Dist. No. 360

Certificate of Death

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa, Idaho
c. LENGTH OF STAY (In this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Boulevard Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho 141
d. STREET ADDRESS (If rural, give location): 1010½ Denver

3. NAME OF DECEASED (Type or Print)
a. (First): WALTER
b. (Middle): CALVIN 284
c. (Last): UPHOUSE

4. DATE OF DEATH (Month) 12 (Day) 3 (Year) 67

5. SEX: M
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 20, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months 8, Days 13 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mason 21
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): Dacenport, Nebraska
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Unknown — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Caroline Walters — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-18-3603
17. INFORMANT'S OWN SIGNATURE: Mrs. Gladys Uphouse — ADDRESS:

18. CAUSE OF DEATH 4500
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cardiac Decompensation

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerosis
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — Bilateral Cataracts

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-19, 1967, *to* 12-3-, 1967, *that I last saw the deceased alive on* 11-30, 1967, *and that death occurred at* 3:20 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE 560 (Degree or title): Henry C. Wesche M.D.
23b. ADDRESS: Nampa — Idaho
23c. DATE SIGNED: 12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/5/67
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Dec. 8, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Lucy M. Flahiff
LICENSE NO.: E 393

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flahiff Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 29 1987
MAY 7 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5417
Local Reg. No. 203
Reg. Dist. No. 360

BIRTH NO. DEC 1 51967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Bureau of Vital Statistics

1. PLACE OF DEATH — 141
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital — 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell — 141
d. STREET ADDRESS (If rural, give location): 321 Aven St.

3. NAME OF DECEASED (Type or Print)
a. (First): Elsie
b. (Middle): Sant
c. (Last): Howell

4. DATE OF DEATH: (Month) (Day) (Year): Dec. 5, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 29, 1895

9. AGE (In years last birthday): 71
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Treasureton, Franklin Co, Ida.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Sant
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Ann Treasure
BIRTHPLACE: Fluer DeLuce Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 528-28-3438A

17. INFORMANT'S OWN SIGNATURE: Mason Howell
ADDRESS:

18. CAUSE OF DEATH — 4445
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Uremia
INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Hypertensive Disease

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS: Arteriosclerotic Heart Disease
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 5-21-59, 19__, *to* 12-5-67, 19__, *that I last saw the deceased alive on* 12-5-67, 19__, *and that death occurred at* 1:25A. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 178 (Degree or title)

23b. ADDRESS: 222 East Elm--Caldwell, Idaho

23c. DATE SIGNED: 12-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 8, 1967

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Dec. 14, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Kenneth E. Spence

LICENSE NO.: E-395

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5418
Local Reg. No. 210
Reg. Dist. No. 360

Certificate of Death

RECEIVED DEC 20 1967 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Notus 140
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Dolliver
b. (Middle): Jennings
c. (Last): Prickett

4. DATE OF DEATH (Month) (Day) (Year): Dec. 7, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 21, 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Lake City, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Prickett — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Lola Gifford — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 484-09-5888
17. INFORMANT'S OWN SIGNATURE: Gary Dean Prickett — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 8 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Arteriosclerotic Heart Disease — 15 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Ca of prostate with bony metastases

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-24-59, 19__, *to* 12-7-67, 19__, *that I last saw the deceased alive on* 12-7-67, 19__, *and that death occurred at* 3:55P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 250 (Degree or title)
23b. ADDRESS: 222 East Elm--Caldwell, Idaho
23c. DATE SIGNED: 12-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Kenneth E. Spence
LICENSE NO.: E-395

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 3 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 26 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5419
Local Reg. No. 200
Reg. Dist. No. 360

RECEIVED DEC 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 141 Canyon
b. CITY OR TOWN Caldwell
LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Arimo 030
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) K. c. (Last) Tarbet

4. DATE OF DEATH: (Month) (Day) (Year) Dec. 7, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 18, 1879

9. AGE (In years last birthday): 87 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Logan, Utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Tarbet
BIRTHPLACE: Utah

14. MOTHER'S MAIDEN NAME: Martha Pearson
BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-10-9878A

17. INFORMANT'S OWN SIGNATURE: Mrs Darrell Norris
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

260X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Nov, 1967, *to* 7 Dec, 1967, *that I last saw the deceased alive on* 7 Dec, 1967, *and that death occurred at* 7:00 m., *from the causes and on the date stated above.*

23a. SIGNATURE: R L Poulsen 651 (Degree or title) MD
23b. ADDRESS: 222 East Logan Caldwell
23c. DATE SIGNED: 11 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Dec. 10, 1967
24c. NAME OF CEMETERY OR CREMATORY: Arimo Cemetery
24d. LOCATION (City, town, or county) (State): Arimo, Idaho

DATE REC'D BY LOCAL REG.: Dec. 13, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Kenneth E Spence
LICENSE NO.: E-395

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

AUG 28 1972

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5420
Local Reg. No. 209
Reg. Dist. No. 360

BIRTH NO. RECEIVED STATE OF IDAHO

DEC 20 1967

Bureau of Vital Statistics

142

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Midland Manor Nursing Home 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 142
d. STREET ADDRESS (If rural, give location): English Apt.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lloyd	L.	Field	Dec. 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed 2	Dec. 5, 1900	67		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Railroad 10
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edgar Field — BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Ruth Allebaugh — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-26-0937
17. INFORMANT'S OWN SIGNATURE: Laura Marie Suter — ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

350X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Parkinsons disease — INTERVAL BETWEEN ONSET AND DEATH: 10 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis — 20 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 ____, 1964, *to* Dec 20, 1966, *that I last saw the deceased alive on* ____, 1966, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Harold W Bowen 062 (Degree or title) M.D.
23b. ADDRESS: Med Center Nampa Ida
23c. DATE SIGNED: Dec 14 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 11, 1967	Wilder Cemetery	Wilder, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 18, 1967	Mrs. Martin Walmsley	Fennett E. Spence	E-395

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 20 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5421
Local Reg. No. 201
Reg. Dist. No. 360

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: CANYON 142 DEC 14 1967 0-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (In this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 142
d. STREET ADDRESS (If rural, give location): 316 12th STREET NORTH
NAMPA, IDAHO

3. NAME OF DECEASED (Type or Print): a. (First) ANDRES b. (Middle) M. c. (Last) GONZALES

4. DATE OF DEATH (Month) (Day) (Year): DEC. 8, 1967

5. SEX: MALE

6. COLOR OR RACE: MEXICAN

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3

8. DATE OF BIRTH: MARCH 25, 1936

9. AGE (In years last birthday): 31
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): WELDER 21

10b. KIND OF BUSINESS OR INDUSTRY: HOMES BROADMORE MOBILE

11. BIRTHPLACE (State or foreign country): CHARLES, TEXAS

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ANDRES GONZALES
BIRTHPLACE: TEXAS

14. MOTHER'S MAIDEN NAME: CAROLINA MARTINEZ
BIRTHPLACE: TEXAS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 457-52-5165

17. INFORMANT'S OWN SIGNATURE: Consuelo L. Gonzales ADDRESS: NAMPA, IDA

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9811

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Gunshot wound chest — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): 3 Homicide

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Street 04

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Nampa 13 Canyon 142 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12 - 8 - 67 11:45 P.M. 2

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X]

21f. HOW DID INJURY OCCUR?: Another man shot him

22. *I hereby certify that I attended the deceased from* Inspection only & Autopsy, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Henry C. Wesche. 583 (Degree or title) 4
23b. ADDRESS: M.D. CORONER, NAMPA, IDAHO
23c. DATE SIGNED: 12-11-67.

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3
24b. DATE: 12-12-67
24c. NAME OF CEMETERY OR CREMATORY: SAN ANTONIO
24d. LOCATION (City, town, or county) (State): SAN ANTONIO, TEXAS

DATE REC'D BY LOCAL REG.: Dec. 13, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
EMBALMER: [signature]
LICENSE NO.: 473
FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

DEC 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 0 6 2001

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5422
Local Reg. No. 207
Reg. Dist. No. 360

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 142 DEC 20 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
c. LENGTH OF STAY (In this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PARKVIEW MANOR 296

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 142
d. STREET ADDRESS (If rural, give location): 951 South Powerline

3. NAME OF DECEASED (Type or Print)
a. (First): GAIL
b. (Middle): F.
c. (Last): Mc REYNOLDS

4. DATE OF DEATH (Month) (Day) (Year): December 8, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: November 14, 1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher- Housewife
10b. KIND OF BUSINESS OR INDUSTRY: School- Home
11. BIRTHPLACE (State or foreign country): Longton Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Andrew J. Cutter 12 — BIRTHPLACE: Kansas
14. MOTHER'S MAIDEN NAME: Lois Belle Fowler — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519 40 1680 B
17. INFORMANT'S OWN SIGNATURE: Guy R McReynolds — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: 2 hr

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c) CVA

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Senility + Arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 1965, *to* Dec 8, 1967, *that I last saw the deceased alive on* 3 Dec, 1967, *and that death occurred at* 6:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph B Norrigan NP 326
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: Dec 12 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery
24d. LOCATION (City, town, or county): Ada County (State): Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Richard W. Mesenbrink — LICENSE NO. E-487
FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 20 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 15 1967

Certificate of Death

STATE OF IDAHO

State File No. 5423
Local Reg. No. 202
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampan Valley
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Oregon 38
b. COUNTY Malheur 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jordan Valley
d. STREET ADDRESS (If rural, give location) P.O. Box 231 Jordan Valley

3. NAME OF DECEASED (Type or Print) a. (First) Noramn b. (Middle) R. c. (Last) Jess
4. DATE OF DEATH (Month) (Day) (Year) Dec. 9, 1967
5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 5, 1901
9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY farming
11. BIRTHPLACE (State or foreign country) Triangle, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME George P. Jess BIRTHPLACE Nova Scotia
14. MOTHER'S MAIDEN NAME Metta E. Tiedeman BIRTHPLACE Washington
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 541-36-2012
17. INFORMANT'S OWN SIGNATURE x Annie Jess ADDRESS Jordan Valley

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 6 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — 9 yrs
DUE TO (c) Arteriosclerotic Vascular Disease — 9 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 6 days
Cerebral Concussion

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-10, 1961, *to* 12-9, 1967, *that I last saw the deceased alive on* 12-9, 1967, *and that death occurred at* 8:05 P *m., from the causes and on the date stated above.*

23a. SIGNATURE E C Horton MD 245 (Degree or Title)
23b. ADDRESS Nampa
23c. DATE SIGNED 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 12, 1967
24c. NAME OF CEMETERY OR CREMATORY Jordan Valley Cemetery
24d. LOCATION (City, town, or county) Jordan Valley (State) Oregon

DATE REC'D BY LOCAL REG. Dec. 14, 1967
REGISTRAR'S SIGNATURE Mrs. Martin Walmsley
25. EMBALMER Richard W. Mesenbrink LICENSE NO. E-487
FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 21 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5424
Local Reg. No. 205
Reg. Dist. No. 360

BIRTH NO.

RECEIVED
DEC 18 1967
Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Blakley's Nursing Home 177

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell 141
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Affa	E	Carlson	Dec. 9, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	October 14, 1881	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Gypsum City, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
M. M. Root	New York	Elizabeth Stiefel	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 518-54-1873
17. INFORMANT'S OWN SIGNATURE: x Carl M. Carlson ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4648

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ? Phlebothrombosis — 3 wks.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Generalized Arteriosclerosis — 10 yrs.
Chronic Brain Syndrome — 2 yrs.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 1, 1967, to 9 Dec, 1967, *that I last saw the deceased alive on* Dec 1, 1967, *and that death occurred at* 6 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lonnie D Price MD 424	Caldwell Ida	12/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 12, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 15, 1967	Mrs. Martine Walmsley	Kenneth E. Spence	E-395

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

Bureau of Vital Statistics

State File No. 5425
Local Reg. No. 208
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 DEC 20 1967
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (In this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 142
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	David	K.	Bott	Dec. 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Sept. 18, 1902	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Service Station Owner	22	Sebawing, Michigan	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Henry Bott	Germany	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		519-07-0295 A	Marjorie A Bott	

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2001 Lymphocytic Lymphosarcoma — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS: adelectases Gastritis, pneumothorax Left lung

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* July 1, 1967, to 12-11, 1967, *that I last saw the deceased alive on* 12-11, 1967, *and that death occurred at* 4 A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	166	Caldwell Idaho	12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 13, 1967	Canyon Hill Cemetery	Caldwell, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 18, 1967	Mrs. Martina Walmsley	Rodney W. Dakan	E-508

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

DUTIES:

JAN 3 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 25 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5426
Local Reg. No. 224
Reg. Dist. No. 360

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JAN 2 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, Idaho
c. LENGTH OF STAY (In this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor Nursing Home 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 140 Middleton, Idaho
d. STREET ADDRESS (If rural, give location) Route #1

3. NAME OF DECEASED (Type or Print)
a. (First) AUDREY
b. (Middle) EVOLINE
c. (Last) STIRM

4. DATE OF DEATH (Month) 12 (Day) 11 (Year) 67

5. SEX F
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH May 30, 1912
9. AGE (In years last birthday) 55 — IF UNDER 1 YEAR Months 6 Days 11 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Emmett, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jim Knee — BIRTHPLACE Prineville, Oregon
14. MOTHER'S MAIDEN NAME Aud Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) No
16. SOCIAL SECURITY NO. 519-38-2879
17. INFORMANT'S OWN SIGNATURE X Fred J. Stirm — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1992 Adenocarcinoma — INTERVAL BETWEEN ONSET AND DEATH 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (Primary not determined)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug 12, 1967, *to* Dec 11, 1967, *that I last saw the deceased alive on* Nov 24, 1967, *and that death occurred at* 4 p *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] MD (Degree or title) 570
23b. ADDRESS Caldwell Ida
23c. DATE SIGNED 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/13/67
24c. NAME OF CEMETERY OR CREMATORY Middleton
24d. LOCATION (City, town, or county) (State) Middleton, Idaho

DATE REC'D BY LOCAL REG. Dec. 22, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Leonard C. Flahiff — LICENSE NO. E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: MAY 8 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5427
Local Reg. No. 213
Reg. Dist. No. 360

RECEIVED DEC 26 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 141 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell, Idaho
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): 141 Caldwell, Idaho
d. STREET ADDRESS (If rural, give location): 2115 Washington

3. NAME OF DECEASED (Type or Print)
a. (First): MINNIE
b. (Middle): LAU
c. (Last): ROSE

4. DATE OF DEATH (Month) 12 (Day) 12 (Year) 67

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 16, 1877
9. AGE (In years last birthday): 90 — IF UNDER 1 YEAR: Months 5 Days 26 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Soda Springs, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME / BIRTHPLACE: Daniel Fredrick Lau Schwaan, Germany
14. MOTHER'S MAIDEN NAME / BIRTHPLACE: Dorothea Zollinger Zurich, Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 519-22-6821
17. INFORMANT'S OWN SIGNATURE / ADDRESS: Fredric D Rose

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

150X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carcinoma of Esophagus

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-12-65, *19*___, *to* 12-12-67, *19*___, *that I last saw the deceased alive on* 12-12-67, *19*___, *and that death occurred at* 1:50P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD 178
23b. ADDRESS: 222 East Elm Caldwell, Idaho
23c. DATE SIGNED: 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/15/67
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn
24d. LOCATION (City, town, or county) (State): Nampa, Idaho

DATE REC'D BY LOCAL REG.: Dec. 22, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Leonard C. Flahiff
LICENSE NO.: E-481
FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 17 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 20 1984

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of disposition of the deceased.

JUN 18 1985

(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5428
Local Reg. No. 211
Reg. Dist. No. 360

Certificate of Death

RECEIVED DEC 26 1967

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY CANYON 142 1-07
b. CITY OR TOWN (If outside corporate limits, write RURAL) NAMPA
c. LENGTH OF STAY (in this place) 7 YRS.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 131 ELMORE 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA 142
d. STREET ADDRESS (If rural, give location) 131 ELMORE

3. NAME OF DECEASED (Type or Print): a. (First) ERNEST b. (Middle) O. c. (Last) DAHLQUIST

4. DATE OF DEATH (Month) (Day) (Year): DEC. 13, 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): MARRIED 3

8. DATE OF BIRTH: NOV. 26, 1893

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 74

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CLERK 10

10b. KIND OF BUSINESS OR INDUSTRY: RAIL ROAD

11. BIRTHPLACE (State or foreign country): MINNESOTA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ERICK O. DAHLQUIST BIRTHPLACE: SWEDEN

14. MOTHER'S MAIDEN NAME: IDA M. MAIMQVIST BIRTHPLACE: SWEDEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 701-16-6798

17. INFORMANT'S OWN SIGNATURE: Daisy O. Dahlquist ADDRESS: NAMPA

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Inspection only, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at 24 C.P. m., from the causes and on the date stated above.

23a. SIGNATURE: Henry C. Wesche (Degree or title) M.D. Coroner 583

23b. ADDRESS: NAMPA, IDAHO

23c. DATE SIGNED: 12-18-67.

24a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL 3

24b. DATE: 12-19-67

24c. NAME OF CEMETERY OR CREMATORY: TACOMA CEMETERY

24d. LOCATION (City, town, or county) (State): TACOMA, WASHINGTON

DATE REC'D BY LOCAL REG.: Dec. 21, 1967

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: W.B. Shepherd LICENSE NO. 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 19 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 30 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

JAN 1 5 1968

Certificate of Death

STATE OF IDAHO

State File No. 5429
Local Reg. No. 25
Reg. Dist. No. 360

BIRTH NO.

~~Bureau of Vital Statistics~~

1. PLACE OF DEATH
a. COUNTY 142 Canyon 1-18
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 18 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho State School & Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Orofino Idaho COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino 180
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Carlton b. (Middle) 052 c. (Last) Mercer
4. DATE OF DEATH (Month) (Day) (Year) December 14, 1967
5. SEX M
6. COLOR OR RACE W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married
8. DATE OF BIRTH August 18, 1918
9. AGE (In years last birthday) 49 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Tyhr, Idaho
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME C. Frantz Mercer BIRTHPLACE Ava, Mo.
14. MOTHER'S MAIDEN NAME Susie Coy BIRTHPLACE Nova Scotia
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Evelyn Fay, CRS ADDRESS Nampa

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) J534 Possible - Bram Neg - Septicemia Non-cultured. — INTERVAL BETWEEN ONSET AND DEATH: 1-30 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cachexia - Autopsy - Splenic Follicular hyperplasia — 1+ wks

DUE TO (c) Mesenteric lymphadenopathy

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Leptomeningitis - Chronic - Fibrotic inactive Encephalopathy - unknown type — Sev. yrs

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1 May, 19 59, *to* 14 December, 19 67, *that I last saw the deceased alive on* 14 December, 19 67, *and that death occurred at* 6:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D. 443
23b. ADDRESS Nampa, Idaho
23c. DATE SIGNED 1-9-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY Kohler Lawn Cemetery
24d. LOCATION (City, town, or county) Nampa, Idaho (State)

DATE REC'D BY LOCAL REG. Jan. 11, 1968
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Messenbrink
LICENSE NO. E-487
FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 17 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5430
Local Reg. No. 8
Reg. Dist. No. 360

RECEIVED
Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 142 Canyon — JAN 4 1968
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Nampa — c. LENGTH OF STAY (If outside this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor Nursing Home 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa 142
d. STREET ADDRESS (If rural, give location) Nampa, Idaho

3. NAME OF DECEASED (Type or Print) — a. (First) NANCY — b. (Middle) — c. (Last) ECKMAN

4. DATE OF DEATH — (Month) 12 — (Day) 15 — (Year) 67

5. SEX F.

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Sept. 15, 1875

9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife 01

10b. KIND OF BUSINESS OR INDUSTRY home

11. BIRTHPLACE (State or foreign country) Oreana Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Payne — BIRTHPLACE Iowa

14. MOTHER'S MAIDEN NAME Amelia Easterwood — BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-60-2008

17. INFORMANT'S OWN SIGNATURE Ellen M. Eastman — ADDRESS 545 - 4th Ave. So.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 260X Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetes mellitus — 1 yr

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) — **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) — **21c. (CITY, TOWN, OR TOWNSHIP)** (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — **21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — **21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* 5:30A. *m., from the causes and on the date stated above.*

23a. SIGNATURE Walter Reddaway MD, (Degree or title) 217 — **23b. ADDRESS** 619 So. Canyon, Nampa, Idaho — **23c. DATE SIGNED** 12-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** December 18, 67 — **24c. NAME OF CEMETERY OR CREMATORY** Battle Mt. Cemetery — **24d. LOCATION** (City, town, or county) (State) Battle Mt. Nevada

DATE REC'D BY LOCAL REG. Jan. 3, 1968 — **REGISTRAR'S SIGNATURE** Mrs. Martina Walmsley

25. EMBALMER [signature] — LICENSE NO. E-496

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5431
Local Reg. No. 219
Reg. Dist. No. 360

Certificate of Death

RECEIVED
DEC 27 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 142 Nampa
d. STREET ADDRESS (If rural, give location) 315-13th Ave So. (Colonial Apts)

3. NAME OF DECEASED (Type or Print)
a. (First) Mabel
b. (Middle) L.
c. (Last) Dillehay

4. DATE OF DEATH (Month) (Day) (Year) Dec. 16, 1967.

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Nov. 26, 1885
9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Vermillion, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Lockwood Rogers — BIRTHPLACE: Canada
14. MOTHER'S MAIDEN NAME: Myrtilla Wyckoff — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 483-12-9764D
17. INFORMANT'S OWN SIGNATURE: J. Douglas Dillehay — ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventricular Fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 20 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertensive ASHD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from —, 19—, to —, 19—, that I last saw the deceased alive on 12-16, 1967, and that death occurred at 7:28 P.m., from the causes and on the date stated above.*

23a. SIGNATURE: Graydon O'Crow M.D. (Degree or title) 115
23b. ADDRESS: Nampa Idaho
23c. DATE SIGNED: 12-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Mem. Gardens
24d. LOCATION (City, town, or county) (State): Canyon County, Idaho.

DATE REC'D BY LOCAL REG.: Dec. 26, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature]
LICENSE NO. E-496

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

APR 8 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5432
Local Reg. No. 220
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

RECEIVED
DEC 27 1967
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell 141
d. STREET ADDRESS (If rural, give location): 1412 Ellis

3. NAME OF DECEASED (Type or Print)
a. (First): Chester
b. (Middle): William
c. (Last): Groome

4. DATE OF DEATH (Month) (Day) (Year): Dec. 17, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 12, 1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer & Livestock
10b. KIND OF BUSINESS OR INDUSTRY: 04
11. BIRTHPLACE (State or foreign country): Star, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John F. Groome — BIRTHPLACE: Milton, Iowa
14. MOTHER'S MAIDEN NAME: Olive Mussetter — BIRTHPLACE: Milton, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-30-5035
17. INFORMANT'S OWN SIGNATURE: Florence M. Groome, by Lizzie Meeks — ADDRESS: 1412 Mead

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Aortic Stenosis — 10 yrs
DUE TO (c): ASHD — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Dec 17, 1967, *that I last saw the deceased alive on* Dec 17, 1967, *and that death occurred at* 4 pm *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): [illegible] 437
23b. ADDRESS: Caldwell Idaho
23c. DATE SIGNED: 12/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 20, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Dec. 26, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D. Davis
LICENSE NO.: E-399

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5433
Local Reg. No. 222
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH 142
a. COUNTY Canyon 1-18
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 18 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital-Nampa, Ida

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa 142
d. STREET ADDRESS (If rural, give location) 591 Gem St.

3. NAME OF DECEASED (Type or Print)
a. (First) LlOYD
b. (Middle) ALLEN 050
c. (Last) YOWELL Jr.

4. DATE OF DEATH (Month) Dec. (Day) 18, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 30, 1927
9. AGE (In years last birthday) 40 — IF UNDER 1 YEAR Months 0 Days 18 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Wood Working 21
10b. KIND OF BUSINESS OR INDUSTRY Wood Products
11. BIRTHPLACE (State or foreign country) Dalton, Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Lloyd Allen Yowell Sr. BIRTHPLACE Kansas
14. MOTHER'S MAIDEN NAME Julia Bundy BIRTHPLACE Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W. 2
16. SOCIAL SECURITY NO. 519-20-7153
17. INFORMANT'S OWN SIGNATURE x Callen G. Yowell ADDRESS Nampa

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1530

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Inanition secondary to metastatic carcinoma in liver

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Carcinoma of cecum.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Partial small bowel obstruction - pelvic abscess

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION 11-3-67 11-22-67
19b. MAJOR FINDINGS OF OPERATION Ca of cecum with extensive liver metastases.
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-31-67, 19__, *to* 12-18-67, 19__, *that I last saw the deceased alive on* Dec. 18, 1967, *and that death occurred at* 2:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 048
23b. ADDRESS Nampa, Idaho 721 Roosevelt Ave.
23c. DATE SIGNED 12-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 21, 1967
24c. NAME OF CEMETERY OR CREMATORY -Cloverdale Cem.
24d. LOCATION (City, town, or county) (State) Boise, Ada, Idaho

DATE REC'D BY LOCAL REG. Dec. 27, 1967
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Richard W. Mesenbrink
LICENSE NO. E-487

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 28 1967
JAN 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5434
Local Reg. No. 322
Reg. Dist. No. 360

BIRTH NO. RECEIVED STATE OF IDAHO

JAN 3 1968

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma 140
d. STREET ADDRESS (If rural, give location): Rt. # 1, Box 121

3. NAME OF DECEASED (Type or Print)
a. (First): Frederick
b. (Middle): Martin
c. (Last): Herold

4. DATE OF DEATH (Month) (Day) (Year): Dec. 18, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 15, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Westfield, Wisconsin
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Frederick Herold — BIRTHPLACE: Denmark
14. MOTHER'S MAIDEN NAME: Mary Maach — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): War I
16. SOCIAL SECURITY NO.: 518-24-8691
17. INFORMANT'S OWN SIGNATURE: Bertha Herold — ADDRESS:

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-6-65, *19*__, *to* 12-18-67, *19*__, *that I last saw the deceased alive on* 12-18-67, *19*__, *and that death occurred at* 2:30P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 250
23b. ADDRESS: 222 East Elm Caldwell, Idaho
23c. DATE SIGNED: 12-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Parma Cemetery
24d. LOCATION (City, town, or county) (State): Parma, Idaho

DATE REC'D BY LOCAL REG.: Jan. 2, 1968
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Merville D. Davis
LICENSE NO.: E-399

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 12 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 26 1967

Certificate of Death

STATE OF IDAHO

State File No. 5435
Local Reg. No. 212
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 142 — 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 1 MONTH
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): PARK VIEW MANOR 296

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA 142
d. STREET ADDRESS (If rural, give location): 411 8th AVE. SOUTH

3. NAME OF DECEASED (Type or Print): a. (First) FLORENCE b. (Middle) M. c. (Last) GREEN

4. DATE OF DEATH (Month) (Day) (Year): DEC. 19, 1967

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2

8. DATE OF BIRTH: MARCH 8, 1885

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME-MAKER 01

10b. KIND OF BUSINESS OR INDUSTRY: AT HOME

11. BIRTHPLACE (State or foreign country): ASHLAND, NEBRASKA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: ALFRED McCREIGHT — BIRTHPLACE: NO RECORD

14. MOTHER'S MAIDEN NAME: ALICE NO RECORD — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 519-34-9938

17. INFORMANT'S OWN SIGNATURE: Emma M Smith — ADDRESS: NAMPA, IDAHO

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Art Scl CV Disease — 10 Yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

4201

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-20-, 1967, *to* 12-19, 1967, *that I last saw the deceased alive on* 12-18-, 1967, *and that death occurred at* 12:30 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Gerald E Weeks M.D. 559 — **23b. ADDRESS**: NAMPA, IDAHO — **23c. DATE SIGNED**: 12-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — **24b. DATE**: 12-21-67 — **24c. NAME OF CEMETERY OR CREMATORY**: KOHLER LAWN CEMETERY — **24d. LOCATION** (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Dec. 21, 1967 — REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: M. B. Shepherd — LICENSE NO.: 473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 2 6 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5436
Local Reg. No. 223
Reg. Dist. No. 360

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 28 1967 Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: CANYON 142 2-04	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: IDAHO b. COUNTY: CANYON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA c. LENGTH OF STAY (If in this place): 4 MO	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA 142
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MIDLAND MANOR 301	d. STREET ADDRESS (If rural, give location): 616 17th AVE. SO.

3. NAME OF DECEASED (Type or Print) a. (First) NICK b. (Middle) c. (Last) BORGUND			4. DATE OF DEATH (Month) (Day) (Year) DEC. 20, 1967
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2	8. DATE OF BIRTH: AUG. 21, 1883
9. AGE (In years last birthday): 84	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED CARPENTER	10b. KIND OF BUSINESS OR INDUSTRY: 21 CONSTRUCTION	11. BIRTHPLACE (State or foreign country): NORWAY	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JORGEN BORGUND	BIRTHPLACE: NORWAY	14. MOTHER'S MAIDEN NAME: SAMOLINE NO RECORD	BIRTHPLACE: NORWAY
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. 518-18-2861A	17. INFORMANT'S OWN SIGNATURE: M. B. Shepherd	ADDRESS: NAMPA, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

334X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro arteriosclerosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Senility
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Melena - Cause Undetermined

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒
21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1959, *to* Dec 20, 1967, *that I last saw the deceased alive on* Dec 20, 1967, *and that death occurred at* 8:50 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE: J. Mangum Nm (Degree or title) 322	23b. ADDRESS: NAMPA, IDAHO	23c. DATE SIGNED: 12/22/67	
24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	24b. DATE: 12-22-67	24c. NAME OF CEMETERY OR CREMATORY: CLOVERDALE CEMETERY	24d. LOCATION (City, town, or county) (State): BOISE, IDAHO
DATE REC'D BY LOCAL REG.: Dec. 27, 1967	REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley	25. EMBALMER: M. B. Shepherd	LICENSE NO. 473

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: SHEPHERD MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: DEC 28 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5437
Local Reg. No. 4
Reg. Dist. No. 360

RECEIVED JAN 4 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, Idaho
LENGTH OF STAY (in this place) 17da.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, Idaho 142
d. STREET ADDRESS (If rural, give location) Route # 1

3. NAME OF DECEASED (Type or Print) a. (First) ARTHUR b. (Middle) DALE c. (Last) AXTELL

4. DATE OF DEATH (Month) 12 (Day) 21 (Year) 67

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Nov 9, 1917

9. AGE (In years last birthday) 50
IF UNDER 1 YEAR Months 1 Days 12
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carmons Helper 30

10b. KIND OF BUSINESS OR INDUSTRY P F E

11. BIRTHPLACE (State or foreign country) Honey Creek, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Axtell BIRTHPLACE Honey Creek, Iowa

14. MOTHER'S MAIDEN NAME Myrtle Page BIRTHPLACE Honey Creek, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Two

16. SOCIAL SECURITY NO. 561-32-2131

17. INFORMANT'S OWN SIGNATURE Mabel M. Axtell ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1538

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Adenocarcinoma Colon
DUE TO (c) Polyposis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION June 26, 67

19b. MAJOR FINDINGS OF OPERATION Polyposis of Colon c Adenocarcinoma Metastasis

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-9, 19 67, *to* 12-21-67 19, *that I last saw the deceased alive on* 12-20, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 115 — 23b. ADDRESS Nampa Idaho — 23c. DATE SIGNED 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE 12/23/67 — 24c. NAME OF CEMETERY OR CREMATORY Kohlerlawn — 24d. LOCATION (City, town, or county) Nampa, Idaho (State)

DATE REC'D BY LOCAL REG. Jan. 3, 1968 — REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Leonard C. Flahiff — LICENSE NO. E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 1 1 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5438
Local Reg. No. 27
Reg. Dist. No. 360

RECEIVED JAN 15 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 CANYON
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA
LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO
b. COUNTY CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) NAMPA - RURAL 142
d. STREET ADDRESS (If rural, give location) R# 2

3. NAME OF DECEASED (Type or Print) a. (First) ELIZABETH b. (Middle) RAHDOLPH c. (Last) BLEVINS

4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 22, 1967

5. SEX FEMALE

6. COLOR OR RACE WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Feb. 16, 1885

9. AGE (In years last birthday) 82 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Hartville Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jack Jordan
BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Mary Ann Mathews
BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Carolyn Patterson Stone ADDRESS Nampa, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cevebral occlusion - Repeat bouts — INTERVAL BETWEEN ONSET AND DEATH: 6 - months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Nephrosclerosis · Uremia 3 mo of → 3 months

DUE TO (c) Hypertensive C-V disease 30 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept, 1962, *to* 22 Dec, 1967, *that I last saw the deceased alive on* Dec 22, 1967, *and that death occurred at* 10:25A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 443 M.D.

23b. ADDRESS Nampa Idaho

23c. DATE SIGNED 1-9-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 26, 1967

24c. NAME OF CEMETERY OR CREMATORY Canyon Hill Cemetery

24d. LOCATION (City, town, or county) Caldwell (State) Idaho

DATE REC'D BY LOCAL REG. Jan. 12, 1968

REGISTRAR'S SIGNATURE Mrs. Martina Walmsley

25. EMBALMER Richard W. Meredith LICENSE NO. E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 15 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under it inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5439
Local Reg. No. 225
Reg. Dist. No. 360

Certificate of Death

RECEIVED
JAN 2 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: CANYON 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): CALDWELL
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CALDWELL PROGRESSIVE CARE 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Route #1 Marsing 370
d. STREET ADDRESS (If rural, give location): Route #1 Marsing

3. NAME OF DECEASED (Type or Print)
a. (First): ERNEST
b. (Middle): JAMES
c. (Last): STEWART

4. DATE OF DEATH (Month) 12 (Day) 22 (Year) 67

5. SEX: MALE M
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Oct. 18, 1885
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Farm
11. BIRTHPLACE (State or foreign country): Prineville, Oregon
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Erastus Stewart — BIRTHPLACE: Virginia
14. MOTHER'S MAIDEN NAME: Edna Workman — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): W.W.I
16. SOCIAL SECURITY NO.: 519-09-6534
17. INFORMANT'S OWN SIGNATURE: x Mrs Ernest Stewart — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1992

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) malignancy of lungs of throat — INTERVAL BETWEEN ONSET AND DEATH: month

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12-1-67
19b. MAJOR FINDINGS OF OPERATION: Cancer of Cervical nodes.
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-1, 1967, *to* 12-22, 1967, *that I last saw the deceased alive on* 12-22, 1967, *and that death occurred at* 60 AM *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 166
23b. ADDRESS: Caldwell Ida
23c. DATE SIGNED: 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/27/67
24c. NAME OF CEMETERY OR CREMATORY: Kohlerlawn Cemetery
24d. LOCATION (City, town, or county): Nampa, Canyon — (State): Idaho

DATE REC'D BY LOCAL REG.: Dec. 29, 1967
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: [signature] — LICENSE NO.: E-496

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 2 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. NOV 10 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5440
Local Reg. No. 10
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JAN 5 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, 1920 S 10th 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell 141
d. STREET ADDRESS (If rural, give location): 1920 So. 10th

3. NAME OF DECEASED (Type or Print)
a. (First): Daisy
b. (Middle): Frances
c. (Last): Vinson

4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: June 25, 1876
9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Caldwell, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Kinkaid — BIRTHPLACE: Indiana
14. MOTHER'S MAIDEN NAME: Rhoda Morrow — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-50-4227
17. INFORMANT'S OWN SIGNATURE: × F R Vinson — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5-22X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 d.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967 *to* Dec 23, 1967, *that I last saw the deceased alive on* Dec 21, 1967, *and that death occurred at* 8 [illegible] *and on the date stated above.*

23a. SIGNATURE: [signature] 258 (Degree or title)
23b. ADDRESS: Robert H. Jonson, M.D. 222 EAST LOGAN CALDWELL, IDAHO
23c. DATE SIGNED: 1-1-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 26, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Jan. 4, 1968
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Kenneth E. Spence
LICENSE NO.: E-395

FIRM NAME: Dakan Chapel, Caldwell, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5441
Local Reg. No. 1
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
JAN 3 1968
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell 141
d. STREET ADDRESS (If rural, give location): 1515 Arlington St.

3. NAME OF DECEASED (Type or Print): a. (First) Clyde b. (Middle) Herold c. (Last) Mead

4. DATE OF DEATH (Month) (Day) (Year): Dec. 23, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Feb. 3, 1909

9. AGE (In years last birthday): 58
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Zurich, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Mead
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Ida Snell
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 522-14-3479

17. INFORMANT'S OWN SIGNATURE: Bell Mead
ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5810 Post-necrotic cirrhosis of liver — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12/19/67

19b. MAJOR FINDINGS OF OPERATION: Nodular liver & ascites

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 12/23, 1967, *that I last saw the deceased alive on* 12/23, 1967 *and that death occurred at* ** m., *from the causes and on the date stated above.*

23a. SIGNATURE: Gerald C. Bowman M.D. 034 (Degree or title)

23b. ADDRESS: 1809 Ellis Caldwell

23c. DATE SIGNED: 12/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 27, 1967

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Jan. 2, 1968

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Kenneth E. Spence

LICENSE NO.: E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 12 1988

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release -- , the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5442
Local Reg. No. 226
Reg. Dist. No. 360

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 142 — JAN 2 1968
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa — Bureau of Vital Statistics
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Ada
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Kuna 010
d. STREET ADDRESS (If rural, give location): Route #1 Kuna

3. NAME OF DECEASED (Type or Print): a. (First) Percy — b. (Middle) E. — c. (Last) Lowe

4. DATE OF DEATH: (Month) Dec. (Day) 23, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Dec. 25, 1915

9. AGE (In years last birthday): 51 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill worker 06

10b. KIND OF BUSINESS OR INDUSTRY: sugar factory

11. BIRTHPLACE (State or foreign country): Riverside, utah

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lionel Lowe — BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Celia King — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 532-14-9597

17. INFORMANT'S OWN SIGNATURE: Thelma M Lowe — ADDRESS: Kuna

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4908

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Multiple Lobar Pneumonia

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.: Emphysema

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-2- , 1958 , *to* 12-23- , 1967 , *that I last saw the deceased alive on* 12- 23- , 1967 , *and that death occurred at* 12:21P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 454

23b. ADDRESS: 619 So. Canyon, Nampa, Idaho

23c. DATE SIGNED: 12-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 26, 1967

24c. NAME OF CEMETERY OR CREMATORY: Kuna Cemetery

24d. LOCATION (City, town, or county) (State): Ada County Idaho

DATE REC'D BY LOCAL REG.: Dec. 29, 1967

REGISTRAR'S SIGNATURE: Mrs. Martin Walmsley

25. EMBALMER: Richard W. Messenbrink — LICENSE NO.: E-487

FIRM NAME: ALSIP FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

JAN 3 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED Bureau of Vital Statistics

STATE OF IDAHO

State File No. 5443
Local Reg. No. 9
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141 JAN 5 1968
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Middleton 140
d. STREET ADDRESS (If rural, give location): Box 171

3. NAME OF DECEASED (Type or Print): a. (First) Lillian b. (Middle) D. c. (Last) Anderson

4. DATE OF DEATH (Month) (Day) (Year): Dec. 24, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan. 13, 1907

9. AGE (In years last birthday): 60 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): OO

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Yakima, Washington

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Andrew Baxter — BIRTHPLACE: Scotland

14. MOTHER'S MAIDEN NAME: Christina Audstley — BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Lillian Anderson — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1648 Generalized Carcinoma originally — INTERVAL BETWEEN ONSET AND DEATH: 8 Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) in the mediastinum

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Biopsy of subcutaneous metastatic lesion showed Carcinoma

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 1954, 19__, *to* 12-24, 1962, *that I last saw the deceased alive on* 12-24, 1967, *and that death occurred at* 6:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Charles E. Kench (Degree or title): 280

23b. ADDRESS: 1819 Elles St Caldwell Idaho

23c. DATE SIGNED: 1-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY: Middleton Cemetery

24d. LOCATION (City, town, or county) (State): Middleton, Idaho

DATE REC'D BY LOCAL REG.: Jan. 4, 1968

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Bernard E. Spencer — LICENSE NO.: E395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5444
Local Reg. No. 6
Reg. Dist. No. 360

RECEIVED Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon — 142 — JAN 4 1968
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa
STATED LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): D.O.A. Mercy Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 142
d. STREET ADDRESS (If rural, give location): 516-4th. Street South

3. NAME OF DECEASED (Type or Print): a. (First) DANIEL — b. (Middle) D, — c. (Last) FERGUSON

4. DATE OF DEATH: (Month) (Day) (Year): December 24, 1967

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Infant

8. DATE OF BIRTH: Jan. 18, 1966

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant 02

10b. KIND OF BUSINESS OR INDUSTRY: ---

11. BIRTHPLACE (State or foreign country): Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Alvin Ferguson — BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Vera Wolfe — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ---

16. SOCIAL SECURITY NO.: ---

17. INFORMANT'S OWN SIGNATURE: Alvin Ferguson — ADDRESS: 5164 EAST. SO.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

8969

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Viremia — INTERVAL BETWEEN ONSET AND DEATH: uncertain

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-1-, 1967, *to* 12-24, 1967, *that I last saw the deceased alive on* 12-11, 1967, *and that death occurred at* 8:00A. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD

23b. ADDRESS: 345 6th So Canyon

23c. DATE SIGNED: 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY: Hillcrest Memorial Gardens

24d. LOCATION (City, town, or county) (State): Canyon County Idaho

DATE REC'D BY LOCAL REG.: Jan. 3, 1968

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Richard W. Mesenbrink — LICENSE NO.: E-487

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5445
Local Reg. No. 29
Reg. Dist. No. 360

RECEIVED
142 JAN 16 1968
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN: Nampa
LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION: Midland Manor Nursing Home 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN: Caldwell 141
d. STREET ADDRESS (If rural, give location): Rt. # 2

3. NAME OF DECEASED (Type or Print): a. (First) Martha; b. (Middle); c. (Last) Daniels

4. DATE OF DEATH (Month) (Day) (Year): Dec. 25, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Nov. 28, 1869

9. AGE (In years last birthday): 98
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Malad City, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Richards
BIRTHPLACE: Wales

14. MOTHER'S MAIDEN NAME: Margaret Morgan
BIRTHPLACE: Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-62-0222T

17. INFORMANT'S OWN SIGNATURE / ADDRESS: W. L. Daniels

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4288

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized ASHD
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Dec. , 1966, *to* Dec. , 1967, *that I last saw the deceased alive on* Dec. 25, 1967, *and that death occurred at* A m., *from the causes and on the date stated above.*

23a. SIGNATURE Gordon O'Brien 115 (Degree or title) MD
23b. ADDRESS Nampa Idaho
23c. DATE SIGNED 1-10-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery
24d. LOCATION (City, town, or county) (State): Caldwell, Idaho

DATE REC'D BY LOCAL REG.: Jan. 15, 1968
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: Kenneth E. Spence
LICENSE NO.: E-395
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

APR 10 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5446
Local Reg. No. 2[illegible]
Reg. Dist. No. 360

Certificate of Death

RECEIVED
JAN 3 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parma 140
d. STREET ADDRESS (If rural, give location): Box 633

3. NAME OF DECEASED (Type or Print)
a. (First): Gertrude
b. (Middle): V.
c. (Last): Hicks

4. DATE OF DEATH (Month) (Day) (Year): Dec. 25, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Nov. 13, 1884
9. AGE (In years last birthday): 83 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Marshall, Minnesota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Hicks — BIRTHPLACE: New York
14. MOTHER'S MAIDEN NAME: Mary Markell — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-46-1275AA
17. INFORMANT'S OWN SIGNATURE: Elsie M. Robinson — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

330X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: ?

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): HCVD
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: —

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): — m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 12/24, 1967, *to* 12/25, 1967, *that I last saw the deceased alive on* 12/25, 1967, *and that death occurred at* 10A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Gerald C Bauman 034 (Degree or title) MD
23b. ADDRESS: Caldwell, Ida
23c. DATE SIGNED: 12/28/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Parma Cemetery
24d. LOCATION (City, town, or county) (State): Parma, Idaho

DATE REC'D BY LOCAL REG.: Jan. 2, 1968
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Kenneth E Spence
LICENSE NO.: E-395

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Chapel, Caldwell, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 16 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 9 - 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5447
Local Reg. No. 17
Reg. Dist. No. 360

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Canyon 142
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Midland Manor 301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, 141
d. STREET ADDRESS (If rural, give location) Rt. # 5

3. NAME OF DECEASED (Type or Print) a. (First) Robert b. (Middle) M. c. (Last) Conway

4. DATE OF DEATH (Month) (Day) (Year) December 25, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Feb. 17, 1880	87				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ogden, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Michael P. Conway BIRTHPLACE Canada
14. MOTHER'S MAIDEN NAME Frances Spurge BIRTHPLACE Penn.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-62-2288T
17. INFORMANT'S OWN SIGNATURE Mrs R W Conway ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arter. Scl. C.V. Dis C Senile Deterioration Yrs
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
—	—	YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
—		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7-6-, 1944, *to* 12-25, 1967, *that I last saw the deceased alive on* 12-24-, 1967, *and that death occurred at* 8:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Gerald E. Weeks	MD 559	Nampa Idaho	12-31-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 29, 1967	Lower Boise Cemetery	Parma, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 5, 1968	Mrs Martina Walmsley	Kenneth E Spence	E-395

FIRM NAME: Dakan Chapel, Caldwell, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 11 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5448
Local Reg. No. 5
Reg. Dist. No. 360

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

JAN 4 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: CANYON 142 3-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA
c. LENGTH OF STAY (in this place): 4 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MERCY HOSPITAL 050

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA 142
d. STREET ADDRESS (If rural, give location): 903 11th AVE. SO.

3. NAME OF DECEASED (Type or Print)
a. (First): JAMES
b. (Middle): BOSAS
c. (Last):

4. DATE OF DEATH (Month) (Day) (Year): DEC. 25, 1967

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED 2
8. DATE OF BIRTH: DEC. 7, 1878
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED FARMER 04
10b. KIND OF BUSINESS OR INDUSTRY: FARMING
11. BIRTHPLACE (State or foreign country): GREECE
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: NO RECORD — BIRTHPLACE: NO RECORD
14. MOTHER'S MAIDEN NAME: NO RECORD — BIRTHPLACE: NO RECORD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 519-58-9779
17. INFORMANT'S OWN SIGNATURE: La Velle Carter — ADDRESS: NAMPA, IDAHO

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic heart disease — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility. Cerebral arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct 25, 1967, *to* Dec 25, 1967, *that I last saw the deceased alive on* Dec 25, 1967, *and that death occurred at* 11:50A *m, from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 766
23b. ADDRESS: NAMPA, IDAHO
23c. DATE SIGNED: 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 12-28-67
24c. NAME OF CEMETERY OR CREMATORY: KOHLERLAWN CEMETERY
24d. LOCATION (City, town, or county) (State): NAMPA, IDAHO

DATE REC'D BY LOCAL REG.: Jan. 3, 1968
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: M. B. Shepherd
LICENSE NO.: 473

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: SHEPHERD MORTUARY

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5449
Local Reg. No. 14
Reg. Dist. No. 360

BIRTH NO.

JAN 9 - 1968

Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 36-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Caldwell Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Adams 020
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Meadows
d. STREET ADDRESS (If rural, give location): ----

3. NAME OF DECEASED (Type or Print): a. (First) CLARA b. (Middle) ELIZABETH 051 c. (Last) MEYER

4. DATE OF DEATH: (Month) Dec. (Day) 27 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Aug. 10, 1893

9. AGE (In years last birthday): 74 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Sheridan, Wyoming

12. CITIZEN OF WHAT COUNTRY?: US

13. FATHER'S NAME: Hudson J. Hubbard — BIRTHPLACE: ----

14. MOTHER'S MAIDEN NAME: Zelpha Parks — BIRTHPLACE: ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-34-2342

17. INFORMANT'S OWN SIGNATURE: Charles A Meyer — ADDRESS: Council, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) _____

DUE TO (c) _____

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — years

19a. DATE OF OPERATION — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify) — **21b. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) — **21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)**

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. — **21e. INJURY OCCURRED** WHILE AT WORK ☐ NOT WHILE AT WORK ☐ — **21f. HOW DID INJURY OCCUR?**

22. *I hereby certify that I attended the deceased from* Dec 27 19 67 *to* _____, 19___, *that I last saw the deceased alive on* Dec 27, 19 67, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD 570 — **23b. ADDRESS**: Caldwell, Idaho — **23c. DATE SIGNED**: 1-9-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3 — **24b. DATE**: Dec. 28, 1967 — **24c. NAME OF CEMETERY OR CREMATORY**: Hillcrest Cemetery — **24d. LOCATION** (City, town, or county) (State): Weiser Idaho

DATE REC'D BY LOCAL REG.: Jan. 5, 1968 — **REGISTRAR'S SIGNATURE**: Mrs Martha Walmsley — **25. EMBALMER**: Marshall S. Henderson — **LICENSE NO.**: E-464

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Northam-Jones Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 2 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 1 0 1968

JAN 1 6 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5450
Local Reg. No. 8
Reg. Dist. No. 360

Certificate of Death

RECEIVED JAN 5 1968 Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home, 919 Denver st. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Caldwell 141
d. STREET ADDRESS (If rural, give location): 919 Denver St.

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Edmond
c. (Last): Robison

4. DATE OF DEATH (Month) (Day) (Year): Dec. 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: Sept. 29, 1909
9. AGE (In years last birthday): 58 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 00
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pryor, Oklahoma
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Robison — BIRTHPLACE: Missouri
14. MOTHER'S MAIDEN NAME: Alma Hulbert — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-16-7440
17. INFORMANT'S OWN SIGNATURE: x Agnes Jameson — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Inspection & history only, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Henry C. Wesche M.D., Coroner 583
23b. ADDRESS: 4 Nampa Idaho
23c. DATE SIGNED: 12-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Ten Davis Cemetery
24d. LOCATION (City, town, or county) (State): Parma, Idaho

DATE REC'D BY LOCAL REG.: Jan. 4, 1968
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Kenneth E. Spence
LICENSE NO.: E-395

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5451
Local Reg. No. 21
Reg. Dist. No. 360

RECEIVED JAN 15 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Canyon 140 — b. CITY OR TOWN: Nampa — LENGTH OF STAY (in this place): 40 yrs — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 612 11th Ave. So., Nampa

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). — a. STATE: Idaho — b. COUNTY: Canyon — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 142 — d. STREET ADDRESS (If rural, give location): 612 11th Ave. So.

3. NAME OF DECEASED (Type or Print): a. (First) Elizabeth — b. (Middle) A. — c. (Last) Mitchell Mathisen

4. DATE OF DEATH: (Month) Dec. (Day) 29, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 27, 1901

9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): Waterloo, Iowa

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William M. Mitchell — BIRTHPLACE: No Record

14. MOTHER'S MAIDEN NAME: Leura Frances Mills — BIRTHPLACE: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 201-49-730

17. INFORMANT'S OWN SIGNATURE: x Harley Mathisen — ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 4291 Myocardial infarction, acute — INTERVAL BETWEEN ONSET AND DEATH: 5 min.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Arteriosclerosis, marked, coronary arteries.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 3:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD 948

23b. ADDRESS: Nampa, Idaho 721 Roosevelt Ave.

23c. DATE SIGNED: 1-5-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 1/2/68

24c. NAME OF CEMETERY OR CREMATORY: Cloverdale Cemetery

24d. LOCATION (City, town, or county) (State): Boise, Ada Co., Idaho

DATE REC'D BY LOCAL REG.: Jan. 11, 1968

REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley

25. EMBALMER: [signature]

LICENSE NO.: E-447

FIRM NAME: Alsip Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 16 1979

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5452
Local Reg. No. 13
Reg. Dist. No. 360

RECEIVED JAN 9 - 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 142 Canyon
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Nampa, Idaho
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkview Manor 396

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon, 117
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell, Idaho
d. STREET ADDRESS (If rural, give location) 312 Denver

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
GEORGIA	IONE	GLENN	12	29	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widowed 2	Feb 25, 1888	79	10	4		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Idaho Springs, Colo.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Frank Louk — BIRTHPLACE Wisconsin
14. MOTHER'S MAIDEN NAME Gnetty Hoover — BIRTHPLACE Colorado

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-30-2229
17. INFORMANT'S OWN SIGNATURE John E. Glenn, Jr. ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1797 Hypostatic pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple metastasis
DUE TO (c) CA of left breast — 2 years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1967, *to* December, 1967, *that I last saw the deceased alive on* Dec. 29, 1967, *and that death occurred at* 5 p.m. m., *from the causes and on the date stated above.*

23a. SIGNATURE 258 (Degree or Title) — 23b. ADDRESS 222 East Logan, Caldwell, Ida. — 23c. DATE SIGNED 1/4/68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — 24b. DATE 1/2/68 — 24c. NAME OF CEMETERY OR CREMATORY Canyon Hill — 24d. LOCATION (City, town, or county) Caldwell, Idaho (State)

DATE REC'D BY LOCAL REG. Jan. 5, 1968 — REGISTRAR'S SIGNATURE Mrs. Martina Walmsley — 25. EMBALMER Leonard C. Flahiff — LICENSE NO. E-481

FIRM NAME: Flahiff Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 11 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 1 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 20 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5453
Local Reg. No. 39
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 22 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: CANYON 142 1-06
b. CITY OR TOWN: NAMPA,
LENGTH OF STAY (in this place): 6 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address or location): 211 11th Ave So EXT. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: CANYON
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): NAMPA 142
d. STREET ADDRESS (If rural, give location): 211 11th Ave So Ext.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
ALICE	RAY	SANG	DEC	29	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	WIDOWED 2	MAY 15, 1881	86	7	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSEWIFE 01	HOUSEWIFE	WILLISTON N. DAKOTA	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
WILLIS MAJOR	WISCONSIN	ALICE A. COVERT	MINN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	543242091JI	X Mrs. L. B. Dickerson	NAMPA, IDA

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Prostate (Cancer Suspected)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Senility

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1960, *to* 12/29, 1967, *that I last saw the deceased alive on* 12/29, 1967, *and that death occurred at* 2:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. R. Mangum M.D. 322	Nampa Idaho	Jan. 22 68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
BURIAL	JAN 2, 1968	CLOVERDALE MEMORIAL	BOISE IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 19, 1968	Mrs. Martina Walmsley	W. B. Shepherd	473

FIRM NAME: SHEPHERD MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5454
Local Reg. No. 28
Reg. Dist. No. 360

Certificate of Death

STATE OF IDAHO

BIRTH NO. RECEIVED

JAN 16 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Canyon 141
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 051

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Caldwell 141
d. STREET ADDRESS (If rural, give location) Caldwell Labor Camp

3. NAME OF DECEASED (Type or Print)
a. (First) Miguel
b. (Middle)
c. (Last) Rodriquez

4. DATE OF DEATH (Month) (Day) (Year) Dec. 30, 1967

5. SEX Male
6. COLOR OR RACE Mexican
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH Nov. 10, 1941
9. AGE (In years last birthday) 26 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Rio, Grand, Texas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 455-64-2729
17. INFORMANT'S OWN SIGNATURE Charles W. Pettifort Chief of Police — ADDRESS Caldwell, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot wound chest

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Justifiable Homicide
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify) 3 Homicide
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) on street by tavern 04
21c. (CITY, TOWN, OR TOWNSHIP) 13 (COUNTY) 142 (STATE) ~~Nampa~~ Caldwell, Canyon Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-30-67 10 P. m. 2
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Shot by an officer in self defense

22. *I hereby certify that I attended the deceased from* Inspection & Autopsy, *19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* about 10 P. *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Henry C. Wesche M.D. Coroner 583 4
23b. ADDRESS Nampa - Idaho
23c. DATE SIGNED 1-11-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE Jan. 6, 1968
24c. NAME OF CEMETERY OR CREMATORY McAllen Cemetery
24d. LOCATION (City, town, or county) (State) McAllen, Texas

DATE REC'D BY LOCAL REG. Jan. 15, 1968
REGISTRAR'S SIGNATURE Mrs. Martina Walmsley
25. EMBALMER Rodney W. Dakan
LICENSE NO. E-508

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Dakan Funeral Chapel, Caldwell, Ida.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5455
Local Reg. No. 11
Reg. Dist. No. 360

BIRTH NO.

RECEIVED JAN 9 - 1968 Bureau of Vital Statistics

142 1-04

1. PLACE OF DEATH
a. COUNTY: Canyon
b. CITY OR TOWN: Nampa
c. LENGTH OF STAY (In this place): 4 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Mercy Hospital-Nampa, Ida.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Canyon
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Nampa 142
d. STREET ADDRESS (If rural, give location): 1515 3rd St., No., Nampa, Ida.

3. NAME OF DECEASED (Type or Print)
a. (First): Paul
b. (Middle): F. 050
c. (Last): Hernandez

4. DATE OF DEATH: (Month) Dec. (Day) 30, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: Spanish
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Nov. 6, 1963
9. AGE (In years last birthday): 4
IF UNDER 1 YEAR: Months 1 Days 24
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None 00
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Nampa, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hernandez
BIRTHPLACE: Minnesota
14. MOTHER'S MAIDEN NAME: Rosa Flores
BIRTHPLACE: Arizona

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X John S Hernandez
ADDRESS: Nampa, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 3483 Meningoencephalitis
INTERVAL BETWEEN ONSET AND DEATH: 6 Hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 28, 1967 to Dec 30, 1967, that I last saw the deceased alive on Dec 30, 1967, and that death occurred at 9 00 A m., from the causes and on the date stated above.

23a. SIGNATURE (Degree or title): Michael A Tecora MD 801
23b. ADDRESS: 619 South Canyon Nampa Idaho
23c. DATE SIGNED: Jan 2, 1968

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jan. 3, 1968
24c. NAME OF CEMETERY OR CREMATORY: Mt. Calvary Cemetery
24d. LOCATION (City, town, or county) (State): Nampa, Canyon, Idaho

DATE REC'D BY LOCAL REG.: Jan. 5, 1968
REGISTRAR'S SIGNATURE: Mrs. Martina Walmsley
25. EMBALMER: Don C Alsip
LICENSE NO.: E-496
FIRM NAME: ALSIP FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5456
Local Reg. No. 18
Reg. Dist. No. 520-521

BIRTH NO. REC'D DEC 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Caribou 150
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lund - Rural
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): County Road 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Caribou
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lund - Rural 150
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) FREDERICK b. (Middle) ALBERT c. (Last) BLAUER

4. DATE OF DEATH: (Month) December (Day) 14 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	October 2, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Self-employed	Granger Utah	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Christian F. Blauer	Bern, Switzerland	Rozetta Gerber	Bern, Switzerland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	World War I		Ella L Blauer	Bancroft, Idaho

18. CAUSE OF DEATH 4344

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Attack — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Exertion
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. (Deceased had been under Physician's care for several years)

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that deceased was last seen by me on* Dec. 15 *, 19* 67*, and that death occurred at* about 5:00p *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Theodore A Allen 583 (Degree or title)	Caribou County Coroner Soda Springs, Idaho	Dec. 18, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 18, 1967	Lund Cemetery	Lund Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-19-67	Marene Bunn	Jack Henderson	E - 349

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: HENDERSON FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

SEP 10 2014 X2

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5457
Local Reg. No. 1771
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Cassia 161 JAN 2 1968 1-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley
c. LENGTH OF STAY (In this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Burley Nursing Home 290

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert 340
d. STREET ADDRESS (If rural, give location) south 5th street Rupert Idaho

3. NAME OF DECEASED (Type or Print) a. (First) Maurice b. (Middle) Fowler c. (Last) Welch

4. DATE OF DEATH (Month) (Day) (Year) Nov 2 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 21 1889
9. AGE (In years last birthday) 80 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired U.S.Govt Employee
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Clearfield Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME 08 BIRTHPLACE George Daniel Welch Pennsylvania
14. MOTHER'S MAIDEN NAME BIRTHPLACE Clara Salome Shivey Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-09-4926
17. INFORMANT'S OWN SIGNATURE E Berryle Baker ADDRESS Rupert

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction 4201 — INTERVAL BETWEEN ONSET AND DEATH few months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arteriosclerosis — years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ch. brain syndrome — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-11, 1966, *to* 11-2, 1967, *that I last saw the deceased alive on* 1-25, 1967, *and that death occurred at* 11 30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Walter B Hurd (Degree or title) 709
23b. ADDRESS Burley Idaho
23c. DATE SIGNED 12-1-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov 4 1967
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG.
REGISTRAR'S SIGNATURE Mildred Nielsen
25. EMBALMER Charles L. Person LICENSE NO. E-494
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 12 1963

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5458
Local Reg. No. 1766
Reg. Dist. No. 470

BIRTH NO.

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Cassia 161 DEC 5 1967 3-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Burley | LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hosp. 070

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Oakley 160
d. STREET ADDRESS (If rural, give location) *

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Hilton	Pratt	Matthews	Nov. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Aug. 26, 1923	44				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Oakley, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
H.P. Matthews	Oakley, Idaho	Clara Bates	Oakley, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	W.W. II 331X	518-44-0540	Elaine Matthews	Oakley, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Sub dural Hematoma - rt — INTERVAL BETWEEN ONSET AND DEATH 24hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cause undetermined
DUE TO (c) (No apparent injury).

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	none	YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
none		

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21f. HOW DID INJURY OCCUR?
none m.		none apparent.

22. *I hereby certify that I attended the deceased from* 1948, 19__, *to* Nov 23, 1967, *that I last saw the deceased alive on* Nov. 23, 1967, *and that death occurred at* 9:45P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R Kutton	M D 514	Burley Idaho	11-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Nov. 27, 1967	Oakley Cemetery	Oakley Cassia, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 4 1967	Beth H. Pearson		E-389

FIRM NAME: Payne Mortuary-Burley, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 6 1967

DEC 12 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 20 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

OCT 2 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5459
Local Reg. No. 1777
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JAN 22 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Cassia 161 1-57
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 57 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley 161
d. STREET ADDRESS (If rural, give location): 1234 Malta Avenue

3. NAME OF DECEASED (Type or Print)
a. (First): Cora
b. (Middle): Elida 070
c. (Last): Bennett

4. DATE OF DEATH (Month) (Day) (Year): Dec. 7, 1967

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Sept. 15, 1880
9. AGE (In years last birthday): 87 — IF UNDER 1 YEAR: Months 2, Days 22 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Atlanta, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: George Edmond Butler, Carthage, Mo.
14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Corinthia Elida Smith, Carthage, Mo.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): - - - -
16. SOCIAL SECURITY NO.: 518-60-3205
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Ferne Majors 1426 Normal Burley Idaho JI

18. CAUSE OF DEATH 9030
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): fat embolism — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): fx lt hip — 5 days
DUE TO (c): fall — 5 days

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: 12-2-67
19b. MAJOR FINDINGS OF OPERATION: Intertrochanteric fx lt Hip
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 01 Home
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Burley 13 Cassia 161, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12 2 67 P m. 2
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☑
21f. HOW DID INJURY OCCUR?: Fall

22. *I hereby certify that I attended the deceased from* 12-2, 1967, *to* 12-7, 1967, *that I last saw the deceased alive on* 12-6, 1967, *and that death occurred at* 3:20 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Walter H. Dane 709
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: 1-17-68

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery
24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Jan. 19 1968
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: Ormand F. Burch
LICENSE NO.: E-471

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: McCULLOCH FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 14 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5460
Local Reg. No. 1769
Reg. Dist. No. 470

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 18 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (If in hospital or institution, give street address or location): 5 Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley 161
d. STREET ADDRESS (If rural, give location): Romney Apts.

3. NAME OF DECEASED (Type or Print)
a. (First): David
b. (Middle): Charles 070
c. (Last): Jensen

4. DATE OF DEATH (Month) (Day) (Year): Dec. 8, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Dec. 3, 1907
9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Insurance Agent 24
10b. KIND OF BUSINESS OR INDUSTRY: Insurance
11. BIRTHPLACE (State or foreign country): Preston, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Antone Jensen — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Eleanor Boreham — BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): W.W. #2 4281
16. SOCIAL SECURITY NO.: 519-34-7093
17. INFORMANT'S OWN SIGNATURE: Mildred H. Jensen — ADDRESS: Burley, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Atherosclerosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 8, 1967, *to* Dec 8, 1967, *that I last saw the deceased alive on* Dec 8, 1967, *and that death occurred at* 2:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): J. R. Kircher MD 283
23b. ADDRESS: Burley Idaho
23c. DATE SIGNED: Dec 9, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/11/67
24c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery
24d. LOCATION (City, town, or county) (State): Preston, Idaho

DATE REC'D BY LOCAL REG.: Dec. 15, 1967
REGISTRAR'S SIGNATURE: Beth H. Pearson
25. EMBALMER: J. Smith Payne
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Payne Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 18 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 2 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5461
Local Reg. No. 1770
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
c. LENGTH OF STAY (in this place): 3 Months 2-03
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Utah 45
b. COUNTY: Duchesne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Roosevelt 555
d. STREET ADDRESS (If rural, give location): ******

3. NAME OF DECEASED (Type or Print)
a. (First): Horace
b. (Middle): LeGrand 070
c. (Last): Allred

4. DATE OF DEATH (Month) (Day) (Year): Dec. 14, 1967

5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Nov. 6, 1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Stockman & Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Agri.
11. BIRTHPLACE (State or foreign country): Salina, Utah
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Stephen Henry Allred 04 — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Hettie Frost — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): none
16. SOCIAL SECURITY NO.: 528-14-6567A
17. INFORMANT'S OWN SIGNATURE: Shall Allred — ADDRESS: Burley, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Anaplastic Carcinoma left main bronchus — INTERVAL BETWEEN ONSET AND DEATH: 3 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Complete obstruction left lung due to Carcinoma — 1½ months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-22, 1967, *to* 12-14, 1967, *that I last saw the deceased alive on* 12-14, 1967, *and that death occurred at* 1:30 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): S. Arnest 012 [illegible]
23b. ADDRESS: Burley, Idaho
23c. DATE SIGNED: 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/19/67
24c. NAME OF CEMETERY OR CREMATORY: Salina Cemetery
24d. LOCATION (City, town, or county) (State): Salina, Utah

DATE REC'D BY LOCAL REG.: 12-27-67
REGISTRAR'S SIGNATURE: Mildred Nielsen (Dept)
25. EMBALMER: J. Garth Payne
LICENSE NO.: E-389

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Payne Mortuary

DUTIES:

JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

MAR 6 1987

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 3 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5462
Local Reg. No. 1772
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Cassia 161 1-50
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): 50 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Burley Nursing Home 290

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley 161
d. STREET ADDRESS (If rural, give location): 1401 Almo Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Nora; b. (Middle); c. (Last) Kinney

4. DATE OF DEATH: (Month) Dec. (Day) 17, (Year) 1967

5. SEX: female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Feb. 2, 1881

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months 10 Days 15
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Parowan, Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jorgen P. Jensen — BIRTHPLACE: Denmark

14. MOTHER'S MAIDEN NAME: Anna Jacobsen, — BIRTHPLACE: Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO. - - - 518-60-3283J1

17. INFORMANT'S OWN SIGNATURE: A. Lowell Holyoak ADDRESS: Route 2 Burley Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute myocardial failure — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) with pulmonary edema Arteriosclerotic cardiovascular disease — Several years

DUE TO (c) Arteriosclerosis generalized

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. (1) Pneumonia (2) Senility — (a) Acute (b) Chronic

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 2-3, 1966, *to* 12-17, 1967, *that I last saw the deceased alive on* 12-17, 1967, *and that death occurred at* 1145 Pm., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) MD 2012

23b. ADDRESS: Burley, Idaho

23c. DATE SIGNED: 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 20, 1967

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View Cemetery

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Dec 29-67

REGISTRAR'S SIGNATURE: Bert A. Pearson

25. EMBALMER: Armand F. Burch

LICENSE NO.: E-471

FIRM NAME: McCulloch Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5463
Local Reg. No. 174
Reg. Dist. No. 470

BIRTH NO.

RECEIVED JAN 10 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Cassia (161) 3-21
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley
LENGTH OF STAY (in this place): 21 Days

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Cassia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Burley (161)
d. STREET ADDRESS (If rural, give location): 301 East 14th Street

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Cassia Memorial Hospital

3. NAME OF DECEASED (Type or Print)
a. (First): Lorin
b. (Middle): McKay (070)
c. (Last): Grow

4. DATE OF DEATH: (Month) Dec. (Day) 30, (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Sept. 16, 1889

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): City Street Superintendant

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Huntsville, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Wood Grow
BIRTHPLACE: Platte Co. Missouri (08)

14. MOTHER'S MAIDEN NAME: Catherine McKay
BIRTHPLACE: Jannettown, Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 518-22-7672

17. INFORMANT'S OWN SIGNATURE: Viola L. Grow
ADDRESS: Burley, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Bronchio-genic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH: 8 mo

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1950, *to* Dec 30, 1967, *that I last saw the deceased alive on* Dec 30, 1967 *and that death occurred at* 12 M. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Colon W. Davis (Degree or title): M.D (135)

23b. ADDRESS: Box 848, Burley Idaho

23c. DATE SIGNED: Jan 3, 1968

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Jan. 2, 1968

24c. NAME OF CEMETERY OR CREMATORY: Pleasant View

24d. LOCATION (City, town, or county) (State): Burley, Idaho

DATE REC'D BY LOCAL REG.: Jan 8 1968

REGISTRAR'S SIGNATURE: Beth H. Pearson

25. EMBALMER: Garth Payne

LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 16 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 10 1968 Bureau of Vital Statistics

State File No. 5464
Local Reg. No. 1773
Reg. Dist. No. 470

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Cassia 161 2-02
b. CITY OR TOWN Burley
LENGTH OF STAY (in this place) 2 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Cassia Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Cassia 160
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Oakley
d. STREET ADDRESS (If rural, give location) **********

3. NAME OF DECEASED (Type or Print)
a. (First) Harry
b. (Middle) Clyde 070
c. (Last) Crouch

4. DATE OF DEATH (Month) (Day) (Year) Dec. 31, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Aug. 8, 1876
9. AGE (In years last birthday) 91
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Railroad Agent
10b. KIND OF BUSINESS OR INDUSTRY Railroad

11. BIRTHPLACE (State or foreign country) Lindley, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Cyrus Augustus Crouch
BIRTHPLACE Tenn.
14. MOTHER'S MAIDEN NAME Louisa Tunnel
BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
16. SOCIAL SECURITY NO. (If yes, give war or dates of service) none 712-05-1161

17. INFORMANT'S OWN SIGNATURE Mrs. A. C. Crouch
ADDRESS Oakley Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of prostate — INTERVAL BETWEEN ONSET AND DEATH 15 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Severe arteriosclerosis — 1 year

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Nov 1967, to Dec 31, 1967, that I last saw the deceased alive on Dec 31, 1967 and that death occurred at 1:55 m., from the causes and on the date stated above.

23a. SIGNATURE John W. Davis (Degree or title) M.D. 135
23b. ADDRESS Box 848, Burley Ida
23c. DATE SIGNED Jan 2, 1968

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal 3
24b. DATE 1/3/68
24c. NAME OF CEMETERY OR CREMATORY Salt Lake City Cemetery
24d. LOCATION (City, town, or county) (State) Salt Lake City, Utah

DATE REC'D BY LOCAL REG. Jan 8, 1968
REGISTRAR'S SIGNATURE Buck A. Pearson
25. EMBALMER
LICENSE NO. E-389
FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 11 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended January 2, 1968

Certificate of Death

STATE OF IDAHO

State File No. 5465
Local Reg. No. 93
Reg. Dist. No. 210

BIRTH NO.

RECEIVED Bureau of Vital Statistics

1. PLACE OF DEATH — a. COUNTY Clearwater — 180 — JAN 2 1968 — 4-09
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino — DURATION OF STAY (In this place) 9 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Clearwater Valley Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Idaho — b. COUNTY Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino -- rural — 180
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) — a. (First) GEORGE — b. (Middle) BUCK — 073 — c. (Last) RYAN
4. DATE OF DEATH — (Month) Dec. — (Day) 4 — (Year) 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Oct. 2, 1912
9. AGE (In years last birthday): 55 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Worker — 17
10b. KIND OF BUSINESS OR INDUSTRY: Lumber
11. BIRTHPLACE (State or foreign country): Delmar, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Robert Ryan — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Katherine Carey — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 520-07-6859
17. INFORMANT'S OWN SIGNATURE: x Edith M. Ryan — ADDRESS: Orofino, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarct
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ARHD
DUE TO (c) Cerebral Ae

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes, Bronchopneumonia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Congestive Heart Failure
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* 12-4, 1967, *that I last saw the deceased alive on* 12-4, 1967, *and that death occurred at* 4:32 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): MD 340
23b. ADDRESS: Box 1330 Orofino Idaho
23c. DATE SIGNED: 12-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY: Weseman
24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Dec. 8, 1967
REGISTRAR'S SIGNATURE: June M. Powell
25. EMBALMER: Tyler C. Gilbertson
LICENSE NO.: 476
FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 93
Reg. Dist. No. 210

BIRTH NO.

RECEIVED
DEC 11 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino
LENGTH OF STAY (in this place): 9 hrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Clearwater Valley Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino-rural
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
George	Buck	Ryan	Dec. 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Oct. 22, 1912	55				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mill worker	lumber	Delmar, Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Robert Ryan	Unk.	Katherine Carey	Unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	520-07-6859	Mrs Buck Ryan	Orofino

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A.S.H.D.
DUE TO (c) Coronary Atherosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Diabetes, Bronchopneumonia, Congestive failure

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 1962, *to* 12-4, 1967, *that I last saw the deceased alive on* 12-4, 1967, *and that death occurred at* 4:32 P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD	Box 1330 Orofino Idaho	12-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	12-7-67	Weseman	Orofino, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 8, 1967	June M. Powell	[signature]	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 11 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 15 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 2 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

SEP 25 1990

PENALTIES: Under the Idaho law, it is a misdemeanor to:

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5466
Local Reg. No. 94
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 180 Clearwater DEC 26 1967 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) R. Orofino
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harmony Heights 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bannock
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 030 Bancroft
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) LUELLA b. (Middle) GUSTA c. (Last) TAYLOR

4. DATE OF DEATH (Month) (Day) (Year): December 9, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married /

8. DATE OF BIRTH: March 9, 1908

9. AGE (In years last birthday): 59
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown 00

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Taylor
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Minnie Corneilson
BIRTHPLACE: North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT'S OWN SIGNATURE: Records
ADDRESS: Christene Plowde Orofino, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

2418

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchial asthma- had attack and was dead on arrival at State Hospital North — INTERVAL BETWEEN ONSET AND DEATH: Several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Mental deficiencywith behavioral reaction, chronic — Many years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept. 10, 1966, *to* Dec. 8, 1967, *that I last saw the deceased alive on* Dec. 8, 1967, *and that death occurred at* 2:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: D.Reed (Degree or title) M.D.595

23b. ADDRESS: Box 672, Orofino, Idaho

23c. DATE SIGNED: Dec. 11, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial /

24b. DATE: 12-13-67

24c. NAME OF CEMETERY OR CREMATORY: Riverside

24d. LOCATION (City, town, or county) (State): Orofino, Idaho

DATE REC'D BY LOCAL REG.: Dec. 20, 1967

REGISTRAR'S SIGNATURE: June M. Powell

25. EMBALMER: Lyle A. Stettmann

LICENSE NO.: 476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5467
Local Reg. No. 97
Reg. Dist. No. 210

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 180 Clearwater
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkia
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 30 Miles S.E. Clarkia

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hayden Lake 280
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Clarence b. (Middle) O 000 c. (Last) Johnson

4. DATE OF DEATH: (Month) 12 (Day) 12 (Year) 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 6-16-03

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Logger 17

10b. KIND OF BUSINESS OR INDUSTRY: Lumber

11. BIRTHPLACE (State or foreign country): Minn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Olaf Johnson
BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Unkow
BIRTHPLACE: Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519 05 9337

17. INFORMANT'S OWN SIGNATURE: Mrs. Grace Johnson
ADDRESS: Hayden Lake Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

4201

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Isabelle Creek

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Clarkia Clearwater Idaho

21d. TIME OF INJURY (Month) 12 (Day) 12 (Year) 67 (Hour) 1 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Larry Dean Winkler 583 Coroner

23b. ADDRESS: 4 Pines Idaho

23c. DATE SIGNED: 12/17/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-15-67

24c. NAME OF CEMETERY OR CREMATORY: Forest

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Dec. 29, 1967

REGISTRAR'S SIGNATURE: June M. Powell

25. EMBALMER: Fred Noland
LICENSE NO.

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 2 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JUL 16 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5468
Local Reg. No. 95
Reg. Dist. No. 210

RECEIVED
Bureau of Vital Statistics
JAN 2 1968

BIRTH NO.

1. PLACE OF DEATH — a. COUNTY: Clearwater (180) — 3-15 — b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino — c. LENGTH OF STAY (In this place): 15 days — d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): CV Hospital (073)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho — b. COUNTY: Clearwater — c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Orofino (180) — d. STREET ADDRESS (If rural, give location): Route 2

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
LAFE		BACUS	December 22 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	divorced 4	July 13, 1910	57				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Millwright 17	Logging	Huntington, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jess Bacus	Missouri	Martha Berry	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-03-9562	X Jim L. Bacus	Orofino, Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Bronchogenic Carcinoma, the Lung	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* May 24, 1967, *to* 22 Dec, 1967, *that I last saw the deceased alive on* 22 Dec, 1967, *and that death occurred at* 3:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] MD 340	Orofino, Idaho	27 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 23, 1967	Weseman	Orofino Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 27, 1967	June M. Powell	Fyle A. Strottmann	476

FIRM NAME: GILBERT'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 23 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 14 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 28 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 2 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5469
Local Reg. No. 96
Reg. Dist. No. 210

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Clearwater (180)
b. CITY OR TOWN: Orofino
c. LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION: Clearwater Valley Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Clearwater
c. CITY OR TOWN: Orofino (180)
d. STREET ADDRESS (If rural, give location): 255 2nd St.

3. NAME OF DECEASED (Type or Print): a. (First) Conrad; b. (Middle) Luther (073); c. (Last) Owen

4. DATE OF DEATH: (Month) Dec. (Day) 26, (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: Jan. 13, 1877

9. AGE (In years last birthday): 90
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Minister (18)

10b. KIND OF BUSINESS OR INDUSTRY: Church

11. BIRTHPLACE (State or foreign country): San Saba, Texas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Erasmus Owen
BIRTHPLACE: Tenn.

14. MOTHER'S MAIDEN NAME: Rhoda Eastman
BIRTHPLACE: Miss.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 528-14-7946

17. INFORMANT'S OWN SIGNATURE: X Elizabeth O Owen
ADDRESS: Orofino

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4933

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH: 12 HRS

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. GENERALIZED ARTERIOSCLEROSIS — 6 YR

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* Dec 26, 1967, *that I last saw the deceased alive on* Dec 26, 1967, *and that death occurred at* 1:00 P.M. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): Calvin A Kebert MD 430
23b. ADDRESS: Orofino, Idaho
23c. DATE SIGNED: Dec. 27 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: Dec. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hazen and Jaeger
24d. LOCATION (City, town, or county) (State): Spokane Washington

DATE REC'D BY LOCAL REG.: Dec. 27, 1967
REGISTRAR'S SIGNATURE: June M. Powell
25. EMBALMER: Lyle A. Strottmann
LICENSE NO.: 476

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: GILBERT'S FUNERAL CHAPEL

DUTIES:

FEB 15 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5470
Local Reg. No. 79
Reg. Dist. No. 380 391

Certificate of Death

RECEIVED
DEC 14 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home-Rural
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. # 1, Box 857 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural - Mountain Home 200
d. STREET ADDRESS (If rural, give location): ¼ mile So. of Mt. Home, Freer Road

3. NAME OF DECEASED (Type or Print)
a. (First): WILFORD
b. (Middle): JOSEPH
c. (Last): PERFECT

4. DATE OF DEATH (Month) (Day) (Year): December 2, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 27, 1906
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Heavy Equipment 11
10b. KIND OF BUSINESS OR INDUSTRY: Construction Operator
11. BIRTHPLACE (State or foreign country): Albia, Iowa
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ben Perfect — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Evelyn Toothman — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): 1925-1928
16. SOCIAL SECURITY NO.: 530-01-5544
17. INFORMANT'S OWN SIGNATURE: Mrs Wilford J. Perfect — ADDRESS: Mt. Home

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): ASHD
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not see alive, investigation only, *, 19__, to ____, 19__, that I last saw the deceased alive on ____, 19__, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE: Arthur Smith — (Degree or title): Coroner 583 4
23b. ADDRESS: Mountain Home, Idaho
23c. DATE SIGNED: 12/3/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/5/67
24c. NAME OF CEMETERY OR CREMATORY: Bruneau Cemetery
24d. LOCATION (City, town, or county) (State): Bruneau, Idaho

DATE REC'D BY LOCAL REG.: Dec 8 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature] — LICENSE NO. E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 14 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 15 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 20 1967

Certificate of Death

STATE OF IDAHO

State File No. 5471
Local Reg. No. 81
Reg. Dist. No. 380 391

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mt Home AFB
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 67 Tac Hosp Mtn Home AFB Id

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 200 Mtn Home
d. STREET ADDRESS (If rural, give location) 1390 E. 5th N. Apt 6

3. NAME OF DECEASED (Type or Print)
a. (First) Patricia
b. (Middle) 585 Ann
c. (Last) Henkins

4. DATE OF DEATH (Month) (Day) (Year) DEC 4 1967

5. SEX: Female
6. COLOR OR RACE: Cau
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Dec 29, 1966
9. AGE (In years last birthday): If under 1 year: Months 11, Days 5; If under 24 hrs.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 0
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Chicago, Illinois
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Donald Henkins — BIRTHPLACE: Chicago, Illinois
14. MOTHER'S MAIDEN NAME: Margaret C. Bonorigo — BIRTHPLACE: Chicago, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Offical Medical Records — ADDRESS:

18. CAUSE OF DEATH 3401
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Meningitis pneumococcic — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 2, 1967, *to* Dec 4, 1967, *that I last saw the deceased alive on* Dec 4, 1967, *and that death occurred at* 7:15p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald S Brooks — DONALD S. BROOKS, CAPT, USAF, MC 585 MD
23b. ADDRESS: Mtn Home AFB Idaho
23c. DATE SIGNED: 5 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 12/6/67
24c. NAME OF CEMETERY OR CREMATORY: Beverly Cemetery
24d. LOCATION (City, town, or county) (State): Oak Lawn, Illinois

DATE REC'D BY LOCAL REG.: Dec 13 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature] — LICENSE NO. E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

JAN 19 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5472
Local Reg. No. 80
Reg. Dist. No. 380 391

RECEIVED
DEC 28 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 200 Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 200 Mountain Home
d. STREET ADDRESS (If rural, give location) 1195 East 8th North

3. NAME OF DECEASED (Type or Print) a. (First) GEORGE b. (Middle) ALBERT c. (Last) BRANSON

4. DATE OF DEATH (Month) (Day) (Year) December 4, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH April 22, 1884
9. AGE (In years last birthday) 83 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Carpenter 21
10b. KIND OF BUSINESS OR INDUSTRY Mill Wright
11. BIRTHPLACE (State or foreign country) Rio Grande Co., Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME T. W. Branson BIRTHPLACE Missouri
14. MOTHER'S MAIDEN NAME Mary Frances Boyd BIRTHPLACE Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 530-05-1202
17. INFORMANT'S OWN SIGNATURE Gillia A Branson ADDRESS Mt. Home, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 332X Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH weeks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arterio & cerebral hemorrhage weeks,

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November 29, 1967, *to* Dec 4, 1967, *that I last saw the deceased alive on* Dec 4, 1967, *and that death occurred at* 3:50 *m., from the causes and on the date stated above.*

23a. SIGNATURE Malcolm N Loebsch 289 (Degree or title) MD
23b. ADDRESS Mountain Home Idaho
23c. DATE SIGNED Dec 8, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/7/67
24c. NAME OF CEMETERY OR CREMATORY Mtn. View Cemetery
24d. LOCATION (City, town, or county) (State) Mountain Home, Idaho

DATE REC'D BY LOCAL REG. Dec 13 1967
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER H. Neil Humphrey
LICENSE NO. E-502
FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5473
Local Reg. No. 83
Reg. Dist. No. 380 391

BIRTH NO. DEC 22 1967

Bureau of Vital Statistics

1. PLACE OF DEATH 200
a. COUNTY Elmore
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home 200
d. STREET ADDRESS (If rural, give location) 195 Jerome

3. NAME OF DECEASED (Type or Print)
a. (First) RALEIGH
b. (Middle) DAILEY
c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year) December 6, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Dec. 10, 1885
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 10
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Padoc, Holt Co., Nebraska
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Smith — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Saletha Hall — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 712-07-7266
17. INFORMANT'S OWN SIGNATURE: Raleigh Smith — ADDRESS: Mtn. Home, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Aortic pneumonitis — days
Pulmonary emphysema — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12 3, 1967, *to* 12.6, 1967 *that I last saw the deceased alive on* 12.6, 1967, *and that death occurred at* 4:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Malone W. Goebsch 289 (Degree or title) MD
23b. ADDRESS: Mountain Home Idaho
23c. DATE SIGNED: 12.12.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/9/67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Dec 13 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: Arthur Smith
LICENSE NO.: E-403

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Smith Mortuary

DUTIES:

DEC 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5474
Local Reg. No. 84
Reg. Dist. No. 380 391

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 26 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Mountain Home 200
d. STREET ADDRESS (If rural, give location): 925 North 6th East

3. NAME OF DECEASED (Type or Print)
a. (First): MRS. b. (Middle): GAIL FOREST c. (Last): KENNEDY

4. DATE OF DEATH (Month) (Day) (Year): December 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: March 25, 1918
9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Raymond, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Steve Green — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Joan Lashbrook — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-30-0816
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Mtn. Home, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Heart Disease c̄ congestive failure — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
advanced rheumatoid arthritis years
adrenal failure due to corticoid medication years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1958, *to* Dec. 7, 1967, *that I last saw the deceased alive on* Dec. 6, 1967, *and that death occurred at* 2:40 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Malone N. Loebsch 289 (Degree or title) — **23b. ADDRESS**: Mountain Home Idaho — **23c. DATE SIGNED**: 12.12.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/9/67
24c. NAME OF CEMETERY OR CREMATORY: Mountain View Cemetery
24d. LOCATION (City, town, or county) (State): Mountain Home, Idaho

DATE REC'D BY LOCAL REG.: Dec 13 1967
REGISTRAR'S SIGNATURE: [signature]
25. EMBALMER: [signature]
LICENSE NO.: E-502

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Smith Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 36-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5475
Local Reg. No. 2
Reg. Dist. No. 380 391

BIRTH NO.

RECEIVED JAN 22 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Mountain Home 200
d. STREET ADDRESS (If rural, give location) Pleasant Acres Trailer Court

3. NAME OF DECEASED (Type or Print) a. (First) IVAN b. (Middle) LESTER c. (Last) BUCY

4. DATE OF DEATH (Month) (Day) (Year) December 31, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Dec. 28, 1910

9. AGE (In years last birthday) 57 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Man 06

10b. KIND OF BUSINESS OR INDUSTRY School Custodian

11. BIRTHPLACE (State or foreign country) Cushing, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry E. Bucy BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Flora Clapp BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-42-4478

17. INFORMANT'S OWN SIGNATURE Mrs Alyce Bucy ADDRESS Mt. Home, Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Anterior Myocardial Infarct — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D. 718

23b. ADDRESS Mountain Home, Idaho

23c. DATE SIGNED 1-4-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 1/4/68

24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery

24d. LOCATION (City, town, or county) Mountain Home, Idaho (State)

DATE REC'D BY LOCAL REG. Jan 15 1968

REGISTRAR'S SIGNATURE Anderson

25. EMBALMER Ward Humphreys

LICENSE NO. E-502

FIRM NAME: Smith Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 22 1968

FEB 2 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5476
Local Reg. No. 1
Reg. Dist. No. 380 391

RECEIVED JAN 22 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Elmore 200
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Elmore Memorial Hospital 080

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Elmore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mountain Home 200
d. STREET ADDRESS (If rural, give location) 150 South 10th East

3. NAME OF DECEASED (Type or Print)
a. (First) CARL
b. (Middle) A.
c. (Last) CARLSON

4. DATE OF DEATH (Month) (Day) (Year) December 31, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH March 9, 1884
9. AGE (In years last birthday) 83 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter - Retired
10b. KIND OF BUSINESS OR INDUSTRY 21 Building
11. BIRTHPLACE (State or foreign country) Sunne, Sweden
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE
14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-22-5818
17. INFORMANT'S OWN SIGNATURE Helen Hanno ADDRESS Pocatello, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4330

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrest.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE Lloyd W. Wells (Degree or title) M.D. 718
23b. ADDRESS Mountain Home, Idaho
23c. DATE SIGNED 1-4-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1/4/68
24c. NAME OF CEMETERY OR CREMATORY Mountain View Cemetery
24d. LOCATION (City, town, or county) (State) Mountain Home, Idaho

DATE REC'D BY LOCAL REG. Jan 15 1968
REGISTRAR'S SIGNATURE T. Sadensa
25. EMBALMER H. Neil Humphrey
LICENSE NO. E-502

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Smith Mortuary

DUTIES: JAN 22 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5477
Local Reg. No. 36
Reg. Dist. No. 540

Certificate of Death

STATE OF IDAHO

BIRTH NO. 67-11966

RECEIVED JAN 9 - 1968

1. PLACE OF DEATH
a. COUNTY Franklin 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston Bureau
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 210 Fairview
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Stacie
b. (Middle) 081
c. (Last) Greene

4. DATE OF DEATH (Month) (Day) (Year) Nov. 14, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never married
8. DATE OF BIRTH Nov. 14, 1967
9. AGE (In years last birthday) IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 12 Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Baby 02
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Preston, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Hal W. Greene BIRTHPLACE Weston, Idaho
14. MOTHER'S MAIDEN NAME Helen Hansen BIRTHPLACE Preston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Hal W. Greene ADDRESS Fairview, Idaho.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

776X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Prematurity - 34 wk.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14, 1967, *to* 11-14, 1967, *that I last saw the deceased alive on* 11-14, 1967, *and that death occurred at* 12 m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD 119
23b. ADDRESS Preston Idaho
23c. DATE SIGNED 11-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY Fairview
24d. LOCATION (City, town, or county) Fairview (State) Idaho

DATE REC'D BY LOCAL REG. 11-16-67
REGISTRAR'S SIGNATURE Eggie W. Brower
25. EMBALMER Osherwin Webb
LICENSE NO. 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

67-11967

BIRTH NO.

RECEIVED JAN 9 - 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5478
Local Reg. No. 35
Reg. Dist. No. 540

1. PLACE OF DEATH
a. COUNTY: Franklin 211
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fairview 210
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Styler
b. (Middle): Hansen 081
c. (Last): Greene

4. DATE OF DEATH (Month) (Day) (Year): Nov. 14 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married 1
8. DATE OF BIRTH: Nov. 14, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours 7 / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baby 021
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Preston, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Hal W. Greene
BIRTHPLACE: Weston, Idaho
14. MOTHER'S MAIDEN NAME: Helen Hansen
BIRTHPLACE: Preston, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Hal W. Greene
ADDRESS: Fairview, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): 776X Premature 34wk
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):
II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-14, 1967 *to* 11-14, 1967, *that I last saw the deceased alive on* 11-14, 1967, *and that death occurred at* 11:19 PM *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] 119
23b. ADDRESS: Preston Idaho
23c. DATE SIGNED: 11-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: Nov. 16, 1967
24c. NAME OF CEMETERY OR CREMATORY: Fairview
24d. LOCATION (City, town, or county) (State): Fairview Idaho

DATE REC'D BY LOCAL REG.: 11-16-67
REGISTRAR'S SIGNATURE: Effie W. Brower
25. EMBALMER: Sherwin Webb
LICENSE NO.: 316

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED Bureau of Vital Statistics STATE OF IDAHO

State File No. 5479
Local Reg. No. 32
Reg. Dist. No. 540

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 211 JAN 2 1968
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston 211
d. STREET ADDRESS (If rural, give location) 26 N 1st E

3. NAME OF DECEASED (Type or Print)
a. (First) Anna
b. (Middle) 081
c. (Last) Forsgren Palmer

4. DATE OF DEATH (Month) (Day) (Year) Dec 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	Aug 4, 1888	79				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	own home	Riverdale, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eli Forsgren		Francis Smith	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Grace Petersen	Preston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4280

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Hypertension Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — 3 yrs
DUE TO (c) Arteriosclerosis — 5 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 1, 19 64 *to* Dec 1, 19 67, *that I last saw the deceased alive on* Dec 1, 1967, *and that death occurred at* 1:17 m., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
O.K. Cutler 122 (Degree or title)	Preston Idaho	12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 11, 1967	Preston Cemetery	Preston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-11-67	Eppie W. Brouwer	Douglas S. Webb	488

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

FEB 22 1980

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or publit records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 24 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5480
Local Reg. No. 33
Reg. Dist. No. 340

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Franklin 211 JAN 2 1968 4-02
b. CITY OR TOWN Preston (Bureau of Vital Statistics) LENGTH OF STAY (in this place) 2 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION General Memorial 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY Franklin
c. CITY OR TOWN Weston 210
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Orson b. (Middle) Lewellyn c. (Last) Olsen

4. DATE OF DEATH (Month) (Day) (Year) Dec. 13, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH January 28, 1888

9. AGE (In years last birthday) 79 | If UNDER 1 YEAR Months | Days | If UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Dry farmer

11. BIRTHPLACE (State or foreign country) Weston, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Orson Olsen BIRTHPLACE

14. MOTHER'S MAIDEN NAME Mary Ann Smith BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Lenore H. Olsen ADDRESS Weston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4280

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) C. V. A — INTERVAL BETWEEN ONSET AND DEATH 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) arteriosclerotic Heart disease — 4 yrs

DUE TO (c) arteriosclerosis — 6 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 9, 1967, to Dec 17, 1967, *that I last saw the deceased alive on* Dec 13, 1967, *and that death occurred at* 1A m., *from the causes and on the date stated above.*

23a. SIGNATURE O. R. Cutler (Degree or title) MD

23b. ADDRESS Weston Idaho

23c. DATE SIGNED 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 16, 1967

24c. NAME OF CEMETERY OR CREMATORY Weston Cemetery

24d. LOCATION (City, town, or county) Weston, Idaho (State)

DATE REC'D BY LOCAL REG. 12-16-67

REGISTRAR'S SIGNATURE Eppie W. Brewer

25. EMBALMER O. Sherwin Webb LICENSE NO. 316

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5481
Local Reg. No. 37
Reg. Dist. No. 540

Certificate of Death

RECEIVED JAN 9 - 1968 3-09

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 211
a. COUNTY Franklin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston Bureau of
c. LENGTH OF STAY (in this place) 9 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial Hospital 081

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston 211
d. STREET ADDRESS (If rural, give location) 8 South 1st West

3. NAME OF DECEASED (Type or Print)
a. (First) Reva
b. (Middle) Lewis
c. (Last) Yaussi

4. DATE OF DEATH (Month) (Day) (Year) Dec. 15, 1967

5. SEX female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Sept 16, 1898
9. AGE (In years last birthday) 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Paris, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John David Lewis — BIRTHPLACE Ut. Salt Lake City
14. MOTHER'S MAIDEN NAME Lucy Smedley — BIRTHPLACE Blackston Del.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Ernest Yaussi — ADDRESS Preston, Idaho

18. CAUSE OF DEATH 5400
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) C V A — INTERVAL BETWEEN ONSET AND DEATH 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Replic ulcer c Hemorrhage — 3 days
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 12-10-67
19b. MAJOR FINDINGS OF OPERATION Hemorrhage (Bodies ulcer)
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-10, 1967, *to* 12-13, 1967, *that I last saw the deceased alive on* 12-13, 1967, *and that death occurred at* 10 A *m., from the causes and on the date stated above.*

23a. SIGNATURE O R Culler (Degree or title) 122 MO
23b. ADDRESS Preston Idaho
23c. DATE SIGNED 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 19, 1967
24c. NAME OF CEMETERY OR CREMATORY Paris Cemetery
24d. LOCATION (City, town, or county) (State) Paris, Idaho

DATE REC'D BY LOCAL REG. 12-19-1967
REGISTRAR'S SIGNATURE Effie W. Brower
25. EMBALMER Douglas S. Webb — LICENSE NO. 488

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Webb Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 20 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5482
Local Reg. No. 24
Reg. Dist. No. 3-40

BIRTH NO.

1. PLACE OF DEATH 211 JAN 2 1968
a. COUNTY Franklin 2-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Preston
c. LENGTH OF STAY (in this place) 3 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Memorial 081

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE California 05
b. COUNTY Los Angles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Los Angles 555
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Ruby b. (Middle) M. c. (Last) Ingram Hill

4. DATE OF DEATH (Month) (Day) (Year) Dec. 19, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Aug. 3, 1905

9. AGE (In years last birthday) 62 | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary 19

10b. KIND OF BUSINESS OR INDUSTRY Office Work

11. BIRTHPLACE (State or foreign country) Brigham City, Utah

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George Wm Ingram — BIRTHPLACE Parry, Utah

14. MOTHER'S MAIDEN NAME Aurelia R. Meacham — BIRTHPLACE Park Valley, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 556 28 7704

17. INFORMANT'S OWN SIGNATURE Mrs. Ray C. Bright — ADDRESS Preston, Idaho

18. CAUSE OF DEATH 5020

MEDICAL CERTIFICATION

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH: 5 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic Bronchitis and Emphysema — 5 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Polycythemia

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1967, 19___, *to* 12/19, 1967, *that I last saw the deceased alive on* 12/19, 1967, *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Leo R. Hawkes M.D. 214

23b. ADDRESS Preston, Idaho

23c. DATE SIGNED 12/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 22, 1967

24c. NAME OF CEMETERY OR CREMATORY Logan Cemetery

24d. LOCATION (City, town, or county) (State) Logan, Utah

DATE REC'D BY LOCAL REG. 12-22-67

REGISTRAR'S SIGNATURE Effie W. Brouwer

25. EMBALMER O. Sherwin Webb — **LICENSE NO.** 316

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: Webb Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5483
Local Reg. No. 77
Reg. Dist. No. 651

BIRTH NO.

RECEIVED DEC 26 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 220 Fremont 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place): 5 min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton 220
d. STREET ADDRESS (If rural, give location): 625 E. Fremont

3. NAME OF DECEASED (Type or Print): a. (First) Rose b. (Middle) Martha c. (Last) Hansen

4. DATE OF DEATH: (Month) Dec. (Day) 5, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: 17 Sept 1894

9. AGE (In years last birthday): 73
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Dixon County, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Karl Kraemer
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Louisa
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): none
(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: 518-05-6607

17. INFORMANT'S OWN SIGNATURE: William R. Hansen ADDRESS: Rexburg

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 4280 Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary heart disease, chronic
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 5, 19 67, *to* _____, 19____, *that I last saw the deceased alive on* Dec. 5, 19 67, *and that death occurred at* 4:20 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 298

23b. ADDRESS: Ashton Idaho

23c. DATE SIGNED: 12-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 8 Dec 1967

24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery

24d. LOCATION (City, town, or county) (State): Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.: 26 Dec 67

REGISTRAR'S SIGNATURE: M. L. Johnson

25. EMBALMER: Robert Q. Bean

LICENSE NO.: E-456

FIRM NAME: Robert Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

MAR 20 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended August 10, 1971

Certificate of Death
STATE OF IDAHO

State File No. 5484
Local Reg. No. 75
Reg. Dist. No. 651

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Fremont	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho b. COUNTY: Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parker c. LENGTH OF STAY (In this place):	b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Parker
d. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTION:	d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First) Delilah	b. (Middle) Beddes	c. (Last) Beck Miller	4. DATE OF DEATH (Month) (Day) (Year)	December 8, 1967		
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: 15 April 1903	9. AGE (In years last birthday): 64	IF UNDER 1 YR. Months / Days	IF UNDER 24 HRS. Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Victor, Idaho	12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME: David Hyrum Beddes	BIRTHPLACE: Hyde Park, Utah	14. MOTHER'S MAIDEN NAME: Elva Tyler	BIRTHPLACE: Fillmore, Utah				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No. (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE: M. D. Hansen	ADDRESS: St. Anthony, Idaho				

4291

18. CAUSE OF DEATH Enter only one cause per line for (a), (b) and (c)	MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
*This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.	I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Myocardial infarction	15 min.
	ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	
	DUE TO (c)	
	II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes ☐ No ☒
21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?	

22. *I hereby certify that I attended the deceased from* none, 19___, *to* none, 19___, *that I last saw the deceased alive on* Dec 8, 1967, *and that death occurred at* 8:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lloyd Barrott, M.D.	23b. ADDRESS: St. Anthony	23c. DATE SIGNED: 12-14-67	
24a. BURIAL, CREMATION, REMOVAL (Specify): Burial	24b. DATE: 11 Dec 67	24c. NAME OF CEMETERY OR CREMATORY: Parker Cemetery	24d. LOCATION (City, town, or county) (State): Parker, Fremont, Idaho
DATE REC'D BY LOCAL REG.: 14 Dec. 67	REGISTRAR'S SIGNATURE: M. D. Hansen	25. EMBALMER: M. D. Hansen	LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service FORM DH-63021

FIRM NAME: Hansen Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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6 1 71

IDAHO DEPARTMENT OF HEALTH

BUREAU OF VITAL STATISTICS

Affidavit to Correct or Amend An Original Certificate of Birth or Death

RECEIVED
AUG 5 - 1971
Statistics

State of Idaho
County of Fremont } ss.

Certificate No. 67-5484

Date Filed

The undersigned does solemnly swear that certain facts on the certificate of death
(Birth or Death)
for Lila Beddes Reck Miller (Name on Original Certificate) who died (Was Born or Died) on Dec. 8, 1967 (Date of Event)
in Parker, Idaho (Place of Event) are erroneous or were omitted; and that, to the best of his knowledge, the true facts are shown by (Bible Record, Insurance Policy, Etc.) prepared on (Give Date), are:

FACTS TO BE CORRECTED ("Name," "Date," "Cause of Death," Etc.)	FROM (As on Original)	TO (The Correct Facts)
Name	Lila Beddes Reck Miller	Delilah Beddes Beck Miller

Subscribed and sworn to before me this 3rd day of August 19 71

Notary Public, residing at St. Anthony, Idaho
My commission expires Dec. 6, 1972
(Seal)

Signed Irene B. Burch
(Signature of parent or attendant if correcting a birth record; of attendant, funeral director, informant if correcting a death record; or other credible person.)

Box 523 St. Anthony Ida
(Street Address, City, State)

SUPPORTING AFFIDAVIT OF A SECOND PERSON

State of Idaho
County of Fremont } ss.

[This Affidavit MUST Also be Executed. (See Chapter 139, 1937 Idaho Session Laws.)]

The undersigned does solemnly swear that he has knowledge of the corrected facts as set forth above and that they are true to the best of his knowledge.

Subscribed and sworn to before me this 3rd day of August 19 71

Notary Public, residing at St. Anthony, Idaho
My commission expires Dec. 6, 1972
(Seal)

Signed Valeen B. Turner
(Signature of Any Credible Person)

806 W. Main St Anthony Ida
(Street Address, City, State)

Form DH 60-155

State File No. 5484
Local Reg. No. 75
Reg. Dist. No. 651

Certificate of Death

STATE OF IDAHO

BIRTH NO.

DEC 15 1967
Bureau of Vital Statistics

1. PLACE OF DEATH 220	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. COUNTY FRemont	a. STATE Idaho b. COUNTY Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Parker	c. LENGTH OF STAY (in this place) 0-00
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) 220 Parker	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000	d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) LILA b. (Middle) BEDDES c. (Last) BECK MILLER

4. DATE OF DEATH (Month) (Day) (Year): Dec., 8, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 15 April 1903

9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Victor, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: David Hyrum Beddes — BIRTHPLACE: Hyde Park, Utah

14. MOTHER'S MAIDEN NAME: Elva Tyler — BIRTHPLACE: Fillmore, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE: M. L. Hansen — ADDRESS: St Anthony Ida

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 15 min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* none, 19__, *to* none, 19__, *that I last saw the deceased alive on* Dec 8 1967, *and that death occurred at* 8:30A *m., from the causes and on the date stated above.*

23a. SIGNATURE: Lloyd Barrett (Degree or title) MD 030

23b. ADDRESS: St Anthony

23c. DATE SIGNED: 12/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 11 Dec 67

24c. NAME OF CEMETERY OR CREMATORY: Parker Cemetery

24d. LOCATION (City, town, or county) (State): Parker, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 14 Dec 67

REGISTRAR'S SIGNATURE: M. L. Hansen

25. EMBALMER: M. L. Hansen — LICENSE NO. E-354

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hansen Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUN 1 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5485
Local Reg. No. 2
Reg. Dist. No. 651

BIRTH NO.

RECEIVED JAN 22 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Fremont 220 3-21
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place): 3 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton 220
d. STREET ADDRESS (If rural, give location): Main Street

3. NAME OF DECEASED (Type or Print)
a. (First): Jess
b. (Middle):
c. (Last): Clark

4. DATE OF DEATH (Month) (Day) (Year): December 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 27 May 1902
9. AGE (In years last birthday): 65 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber 21
10b. KIND OF BUSINESS OR INDUSTRY: Barbering
11. BIRTHPLACE (State or foreign country): Teton, Fremont Co., Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Israel Clark — BIRTHPLACE: Clarkston, Utah
14. MOTHER'S MAIDEN NAME: Julia Ann Stewart — BIRTHPLACE: Clarkston, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-07-6855
17. INFORMANT'S OWN SIGNATURE: X Richard G. Clark — ADDRESS: Ashton, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of splenic flexure of colon & intra abdominal metastases — INTERVAL BETWEEN ONSET AND DEATH: 26½ mo.

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

1531

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 20 Nov., 1967, *to* 10 Dec., 1967, *that I last saw the deceased alive on* 9 Dec., 1967, *and that death occurred at* 2:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. A. Melcher M.D. 352
23b. ADDRESS: Ashton, Idaho
23c. DATE SIGNED: 5 Jan 68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12 Dec 1967
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Fremont Co., Idaho

DATE REC'D BY LOCAL REG.: 18 Jan 68
REGISTRAR'S SIGNATURE: M. S. Hansen
25. EMBALMER: Robert G. Bean
LICENSE NO.: E-456

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Robert Bean Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under it inclusive. In case of facts taken from hospital or public records, the person authorized to [illegible] the facts shall sign HIS name in addition to giving the source of information.

JAN 23 1968

OCT 13 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5486
Local Reg. No. 76
Reg. Dist. No. 651

BIRTH NO.

DEC 15 1967
Bureau of Vital Statistics

1. PLACE OF DEATH 220
a. COUNTY: Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton (Rural) 220
d. STREET ADDRESS (If rural, give location): RFD#1

3. NAME OF DECEASED (Type or Print)
a. (First): ROBERT
b. (Middle): HUDSON
c. (Last): GARVER

4. DATE OF DEATH (Month) (Day) (Year): Dec., 10, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 25 Oct 1893
9. AGE (In years last birthday): 74 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: Self-Employed
11. BIRTHPLACE (State or foreign country): Miund City, Missouri
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Jacob Garver — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Mary Butler — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW I
16. SOCIAL SECURITY NO.: 518-14-8462
17. INFORMANT'S OWN SIGNATURE: Max Garver — ADDRESS: Ashton, Idaho

18. CAUSE OF DEATH 4201
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
GU bleeding, cause unknown — ?

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-10, 1967, *to* _____, 19__, *that I last saw the deceased alive on* 12-10-67, 1967, *and that death occurred at* 6:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 298
23b. ADDRESS: Ashton-Idaho
23c. DATE SIGNED: 12-13-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 13 Dec 67
24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery
24d. LOCATION (City, town, or county) (State): Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 13 Dec 67
REGISTRAR'S SIGNATURE: M L Hansen
25. EMBALMER: M L Hansen
LICENSE NO.: E-354

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hansen Memorial Chapel

DEC 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5487
Local Reg. No.
Reg. Dist. No. 651

RECEIVED JAN 4 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH — 220
a. COUNTY: Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton
LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Ashton Memorial Hospital 083

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Ashton 220
d. STREET ADDRESS (If rural, give location): 405 Highland

3. NAME OF DECEASED (Type or Print): a. (First) WILLIAM b. (Middle) N. c. (Last) HOLCOMB

4. DATE OF DEATH (Month) (Day) (Year): December 14, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 14 October 1897

9. AGE (In years last birthday): 70
IF UNDER 1 YEAR: Months 2 | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 04

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Hemsley, Nebraska

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Charles Isaac Holcomb
BIRTHPLACE: Shenandoah, Iowa

14. MOTHER'S MAIDEN NAME: Mary Mathews
BIRTHPLACE: Bath, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ——

16. SOCIAL SECURITY NO.: 519-03-1155

17. INFORMANT'S OWN SIGNATURE: Family Records
ADDRESS: Robert O Bean

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic heart disease — 5 yrs
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Asthma, bronchial — 2 yrs

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* December, 1967, *to* 12-14-, 1967, *that I last saw the deceased alive on* 12-14-, 1967, *and that death occurred at* 8:50A.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): 298

23b. ADDRESS: Ashton, Idaho

23c. DATE SIGNED: 12-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 16 Dec. 1967

24c. NAME OF CEMETERY OR CREMATORY: Pineview Cemetery

24d. LOCATION (City, town, or county) (State): Ashton, Fremont, Idaho

DATE REC'D BY LOCAL REG.: 3 Jan 68

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Robert O Bean
LICENSE NO.: E-456

FIRM NAME: Bean Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

SEP 22 1977

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 22 1982

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5488
Local Reg. No. 78
Reg. Dist. No. 651

BIRTH NO.

RECEIVED DEC 26 1967 Bureau of Vital Statistics

STATE OF IDAHO

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 220 Fremont
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural West St. Anthony
c. LENGTH OF STAY (In this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Fremont
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Teton 220
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	WILLIAM	STUART	STODDARD	December 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	February 4, 1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Retired Lumberman 17	Sawmill	Beaver Canyon, Idaho	U.S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas William Steddard	Wellsville, Utah	Mary Ann Stuart	Wellsville, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		Fred B. Stoddard	Teton, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* DOA, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	583 (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lou Connell	CORONER 4	Box 123, St. Anthony, Ida.	12-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/20/67	Rexburg	Rexburg Madison Idaho

DATE RECD BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
20 Dec 67	M L Hansen	Bennett Flamm	E347

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 12 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5489
Local Reg. No. 39
Reg. Dist. No. 340-341

Certificate of Death

RECEIVED
DEC 5 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 231
a. COUNTY: Gem 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (In this place): 3days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett 231
d. STREET ADDRESS (If rural, give location): 403 East 4th St

3. NAME OF DECEASED (Type or Print)
a. (First): Frank
b. (Middle):
c. (Last): Hunter

4. DATE OF DEATH (Month) (Day) (Year): Dec. 1, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Nov. 13, 1879
9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer 04
10b. KIND OF BUSINESS OR INDUSTRY: farm
11. BIRTHPLACE (State or foreign country): Creswell, Oregon
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Lloyd Hunter — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Mary E. Sellers — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 541 24 5200
17. INFORMANT'S OWN SIGNATURE: X Lutie Hunter — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4341

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) with Cerebra vascular
DUE TO (c) accident — 3 day

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1950, *to* Dec 1, 1967, *that I last saw the deceased alive on* Nov 30, 1967, *and that death occurred at* 5:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Donald P. Fairbanks 429
23b. ADDRESS: Emmett Idaho
23c. DATE SIGNED: 12/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 4, 1967
24c. NAME OF CEMETERY OR CREMATORY: Emmett
24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Dec 1, 1967
REGISTRAR'S SIGNATURE: Jean A Beatty
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E392

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: The Beatty Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 8 1993

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5490
Local Reg. No. 40
Reg. Dist. No.

BIRTH NO.

RECEIVED
Bureau of Vital Statistics
DEC 14 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 231 Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Emmett
c. LENGTH OF STAY (in this place) 3-07 1wk
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett 231
d. STREET ADDRESS (If rural, give location) Emmett Valley Manor

3. NAME OF DECEASED (Type or Print)
a. (First) Mary
b. (Middle) Margaret
c. (Last) Butler

4. DATE OF DEATH (Month) (Day) (Year) Dec. 5, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH October 27, 1904

9. AGE (In years last birthday) 63
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY home

11. BIRTHPLACE (State or foreign country) Pettersburg, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Martin Bremmer
BIRTHPLACE Germany

14. MOTHER'S MAIDEN NAME Angelia Hopster
BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 01 9680

17. INFORMANT'S OWN SIGNATURE X John W. Butler
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ~~331X~~ Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CVA due to — 10 yrs
DUE TO (c) Hypertensive CV disease — 15 yrs

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 19 [illegible], 19__, *to* Dec 9, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* 6:3[illegible] p. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 184 (Degree or title)

23b. ADDRESS Emmett Ida.

23c. DATE SIGNED 11 Dec. 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Dec. 9, 1967

24c. NAME OF CEMETERY OR CREMATORY Emmett Cemetery

24d. LOCATION (City, town, or county) Emmett (State) Idaho

DATE REC'D BY LOCAL REG. Dec 11, 1967

REGISTRAR'S SIGNATURE Jean A Beatty

25. EMBALMER John W. Beatty

LICENSE NO. E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5491
Local Reg. No. 42
Reg. Dist. No. 340-341

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECE

DEC 26 1967
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Gem 231 3-13	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho b. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett c. LENGTH OF STAY (in this place): 13 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise 011
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hospital	d. STREET ADDRESS (If rural, give location): 6308 W. State

3. NAME OF DECEASED (Type or Print): a. (First) Edna b. (Middle) 085 c. (Last) Mc Lean

4. DATE OF DEATH (Month) (Day) (Year): Dec. 11, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 3, 1890

9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Barnston, Nebraska

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joel B. Dobbs — BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Ella Ellinger — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 570-20-9237B

17. INFORMANT'S OWN SIGNATURE: Carl McLean — ADDRESS: Boise

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 6 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* July, 1954, *to* Dec., 1967, *that I last saw the deceased alive on* Dec 11, 1967, *and that death occurred at* 8:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Wm B. Jewell MD. 260

23b. ADDRESS: 1024 E. Locust, Emmett, Ida

23c. DATE SIGNED: 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-14-67

24c. NAME OF CEMETERY OR CREMATORY: Meridian Cemetery

24d. LOCATION (City, town, or county) (State): Meridian, Idaho

DATE REC'D BY LOCAL REG.: Dec. 20, 1967

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Geo Jerrod

LICENSE NO.: E-366

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Robison Chapel of the Chimes

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5492
Local Reg. No.
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED
DEC 14 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231 3-03
b. CITY OR TOWN Emmett
c. LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Walter Knox Mem. Hosp. 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett 231
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Edgar	Poe	Thomas	Dec. 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	widowed 2	Oct. 14, 1884	83	1	28		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farm	Rome, Illinois	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Lewis Wallace Thomas	Illinois	Denzetta Shaw	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-12-9957A	X George T. Thomas	RR 1 Melba Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PROBABLE MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. SEVERE PARKINSONIAN SYNDROME WITH GENERAL DEBILITY — 5 YEARS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 1960, to Dec 12, 1967, *that I last saw the deceased alive on* Dec 11, 1967, *and that death occurred at* 1:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald P. Lawrence MD 429	Emmett Idaho	12/12/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	12-15-67	Emmett	Emmett, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 12, 1967	Jean A Beatty	Glenn W Beatty	E-392

FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 1 4 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5493
Local Reg. No. 43
Reg. Dist. No. 340-341

RECEIVED DEC 26 1967

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 231
a. COUNTY: Gem 4-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 1hr
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett 231
d. STREET ADDRESS (If rural, give location): 928 So. Hayes

3. NAME OF DECEASED (Type or Print)
a. (First): Alex
b. (Middle): Emanuel
c. (Last): Pearson

4. DATE OF DEATH (Month) (Day) (Year): Dec. 15, 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Oct. 15, 1894
9. AGE (In years last birthday): 73 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: lumber
11. BIRTHPLACE (State or foreign country): Kalwar Lar, Sweden
12. CITIZEN OF WHAT COUNTRY? Sweden

13. FATHER'S NAME: unknown — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 01 7066A
17. INFORMANT'S OWN SIGNATURE: Bertha Pearson — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PROBABLE ACUTE MYOCARDIAL — INTERVAL BETWEEN ONSET AND DEATH: 5 Hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) INFARCTION
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* [illegible], 19[illegible], *to* [illegible], 19[illegible], *that I last saw the deceased alive on* [illegible], 19[illegible], *and that death occurred at* 3 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [illegible] 429 (Degree or title)
23b. ADDRESS: Emmett Idaho
23c. DATE SIGNED: 12/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 18, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sweet
24d. LOCATION (City, town, or county) (State): Sweet, Idaho

DATE REC'D BY LOCAL REG.: Dec. 21, 1967
REGISTRAR'S SIGNATURE: Jean A Beatty
25. EMBALMER: [illegible] W Beatty
LICENSE NO.: E392

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: The Beatty Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 9 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 18 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5494
Local Reg. No. 44
Reg. Dist. No. 340-341

Certificate of Death

STATE OF IDAHO

BIRTH NO.

DEC 26 1967
Bureau of Vital Statistics

1. PLACE OF DEATH a. COUNTY: Gem 231 1-03	2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE: Idaho b. COUNTY: Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett; c. LENGTH OF STAY (in this place): 3yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett 231
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Emmett Valley Manor 086	d. STREET ADDRESS (If rural, give location): Emmett Valley Manor

3. NAME OF DECEASED (Type or Print): a. (First) Gertrude b. (Middle) c. (Last) Lemman

4. DATE OF DEATH (Month) (Day) (Year): Dec. 18, 1967

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: May 13, 1879

9. AGE (In years last birthday): 88 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Hemitie, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George E. Butler — BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: Meeka Melvina Garrett — BIRTHPLACE: Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 535 44 1691

17. INFORMANT'S OWN SIGNATURE: X George F Vehrs — ADDRESS

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) Hypertensive Cardio-Vascular Disease — year

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-11, 19 60, *to* 12-18, 19 67, *that I last saw the deceased alive on* 12-13, 19 67, *and that death occurred at* 2:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE: Harmon E. Holverson (Degree or title) 241 MD

23b. ADDRESS: Emmett, Idaho

23c. DATE SIGNED: 12-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3

24b. DATE: Dec. 20, 1967

24c. NAME OF CEMETERY OR CREMATORY: Ritzville, Washington

24d. LOCATION (City, town, or county) (State): Ritzville, Washington

DATE REC'D BY LOCAL REG.: Dec. 20, 1967

REGISTRAR'S SIGNATURE: Jean A Beatty

25. EMBALMER: Glenn W Beatty — LICENSE NO. E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUL 23 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5495
Local Reg. No. 45
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED DEC 26 1968 4-03 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 231 Gem
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 3 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Memorial Hospital 085

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett 231
d. STREET ADDRESS (If rural, give location): Emmett Valley Manor

3. NAME OF DECEASED (Type or Print): a. (First) Lelia b. (Middle) Ada c. (Last) Breshears

4. DATE OF DEATH (Month) (Day) (Year): Dec. 19, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3

8. DATE OF BIRTH: January 10, 1910

9. AGE (In years last birthday): 57
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: home

11. BIRTHPLACE (State or foreign country): Caldwell, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Albert Hawse
BIRTHPLACE: Des Moines, Iowa

14. MOTHER'S MAIDEN NAME: Stella Craner
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-14-2969

17. INFORMANT'S OWN SIGNATURE: L B Breshears
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CVA — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Abscess of peritoneum — 3 wks.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____ 19__, *to* 12-19, 1967, *that I last saw the deceased alive on* 12-19, 1967, *and that death occurred at* 3:15 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 184 (Degree or title) MD

23b. ADDRESS: Emmett, Ida.

23c. DATE SIGNED: 20 Dec 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 22, 1967

24c. NAME OF CEMETERY OR CREMATORY: Emmett

24d. LOCATION (City, town, or county) (State): Emmett, Idaho

DATE REC'D BY LOCAL REG.: Dec. 21, 1967

REGISTRAR'S SIGNATURE: Jean A. Beatty

25. EMBALMER: Glenn W Beatty
LICENSE NO.: E392
FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 27 1967
JAN 4 1968
MAY 29 2012

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5496
Local Reg. No. 76
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED
DEC 26 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 7 years
d. FULL NAME OF HOSPITAL OR INSTITUTION: Shady Lane Nursing Home 265

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett 231
d. STREET ADDRESS (If rural, give location): Sady Lane Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Arminta	Jane	Brandon	Dec. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	white	Widowed 2	Nov. 1, 1872	95				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
housewife 01	home	Carrollton, Arkansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Jenkins	Tenn.	Georgiann Chaney	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518 62 9771	X A. J. Brandon	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	CONGEST. HEART FAILURE	1 WEEK
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	ARTERIO SCLEROTIC HEART DISEASE	YEARS

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19 50, *to* Dec 20, 1967, *that I last saw the deceased alive on* Dec 19, 1967, *and that death occurred at* 4 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Arnold P. Pemberton 429	Emmett Idaho	12/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 22, 1967	Sweet Cemetery	Sweet Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 23 1967	Jean A. Beatty	Glenn W Beatty	E392

FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each; indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5497
Local Reg. No. 47
Reg. Dist. No. 340-341

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Gem 231
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett
c. LENGTH OF STAY (in this place) 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 516 No. Boise 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Gem
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Emmett 231
d. STREET ADDRESS (If rural, give location) 516 No. Boise

3. NAME OF DECEASED (Type or Print) a. (First) Lulu b. (Middle) c. (Last) Barnes

4. DATE OF DEATH (Month) (Day) (Year) Dec. 22, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	white	widowed 2	Feb. 18, 1885	82				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Beargrove, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME George W. Reed BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Hannah Holsman BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-36-1215
17. INFORMANT'S OWN SIGNATURE X Mary L. Stephens ADDRESS 4137 Burr Lane Ida.

4201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CEREBRAL ACUTE — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) MYOCARDIAL INFARCTION — IMMEDIATE
DUE TO (c) DEAD ON ARRIVAL

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY occur?

22. *I hereby certify that I attended the deceased from* ~~Dec 22~~ (Dec 20), 1967, *to* Dec 22, 1967, *that I last saw the deceased alive on* Dec, 1967, *and that death occurred at* 10:30 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) Konrad P. Faurholm M.D.
23b. ADDRESS Emmett Ida
23c. DATE SIGNED 12/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Dec. 27, 1967
24c. NAME OF CEMETERY OR CREMATORY Emmett
24d. LOCATION (City, town, or county) (State) Emmett, Idaho

DATE REC'D BY LOCAL REG. Dec 23 1967
REGISTRAR'S SIGNATURE Jean A Beatty
25. EMBALMER Glenn W Beatty
LICENSE NO. E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida.

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 8 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5498
Local Reg. No. 48
Reg. Dist. No. 340-341

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gem 231 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Emmett
c. LENGTH OF STAY (in this place): 1 month
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Walter Knox Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boise
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Brownlee 080
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Hazel
b. (Middle): Pearl 085
c. (Last): Biggers

4. DATE OF DEATH (Month) (Day) (Year): Dec. 27, 1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married 3
8. DATE OF BIRTH: Aug. 26, 1906
9. AGE (In years last birthday): 61 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Touchet, Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Francis Elmer Albin — BIRTHPLACE: Devizes, Kan.
14. MOTHER'S MAIDEN NAME: Bessie Caroline Dool — BIRTHPLACE: Osco, Nebr.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Melvin F. Biggers — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF RECTUM WITH METATICES TO LIVER — INTERVAL BETWEEN ONSET AND DEATH: ONE MONTH AGO NOV 20 1967

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) DIAGNOSED →
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION: NOV 30 1967
19b. MAJOR FINDINGS OF OPERATION: Ca of LIVER & RECTUM.
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* NOV 20, 1967, *to* DEC 27, 1967, *that I last saw the deceased alive on* DEC 27, 1967, *and that death occurred at* 10:20a. *m., from the causes and on the date stated above.*

23a. SIGNATURE: Ronald P Rawlins (Degree or title) 429
23b. ADDRESS: Emmett Ida
23c. DATE SIGNED: 1/3/68

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Brownlee
24d. LOCATION (City, town, or county) (State): Brownlee, Idaho

DATE REC'D BY LOCAL REG.: Jan. 3, 1968
REGISTRAR'S SIGNATURE: Jean A. Beatty
25. EMBALMER: Glenn W Beatty
LICENSE NO.: E-392
FIRM NAME: THE BEATTY CHAPEL Emmett, Ida

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 23 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Klingler

Certificate of Death

STATE OF IDAHO

State File No. 5499
Local Reg. No. 3019
Reg. Dist. No. 420

BIRTH NO.

RECEIVED
240
DEC 22 1967

1. PLACE OF DEATH
a. COUNTY: Gooding
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (in this place): 0-00
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gooding Co. Mem. Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Gooding
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding 240
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First): Emma
b. (Middle): Frances 090
c. (Last): Moore

4. DATE OF DEATH: (Month) Dec. (Day) 9, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: May 11, 1887

9. AGE (In years last birthday): 80
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Jewell, Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Steven G. Hoon
BIRTHPLACE: Illinois

14. MOTHER'S MAIDEN NAME: Elizabeth Ann Staley
BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-44-6908

17. INFORMANT'S OWN SIGNATURE: George E Moore
ADDRESS: Gooding, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5705

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Intestinal Obstruction — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Nephritis. — Months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 7, 19 67, *to* Dec 9, 19 67, *that I last saw the deceased alive on* 12-9, 19 ___, *and that death occurred at* 6:31 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Merrill D Klingler MD 285

23b. ADDRESS: Gooding, Idaho

23c. DATE SIGNED: 12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-14-67

24c. NAME OF CEMETERY OR CREMATORY: Elmwood Cemetery

24d. LOCATION (City, town, or county) (State): Gooding Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1967

REGISTRAR'S SIGNATURE: Robert Meyer

25. EMBALMER: Robert Meyer

LICENSE NO.: E-424-

FIRM NAME: Thompson Chapel-Gooding, Ida

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5500
Local Reg. No. 3013
Reg. Dist. No. 420

BIRTH NO.

RECEIVED DEC 22 1967

1. PLACE OF DEATH
a. COUNTY Goodding 240
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Goodding
c. LENGTH OF STAY (in this place) 6 wks.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Idaho T.B. & Chest Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Clearwater 201
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Orofino 180
d. STREET ADDRESS (If rural, give location) P.O. Box 466

3. NAME OF DECEASED (Type or Print)
a. (First) Julian
b. (Middle) Delbert 598
c. (Last) Dahl

4. DATE OF DEATH (Month) 12 (Day) 15 (Year) 1967

5. SEX M

6. COLOR OR RACE W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 6-30-1910

9. AGE (In years last birthday) 57
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer 21

10b. KIND OF BUSINESS OR INDUSTRY Newspaper

11. BIRTHPLACE (State or foreign country) Crookston, Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John S Dahl
BIRTHPLACE Molde Norway

14. MOTHER'S MAIDEN NAME Theodora Grosfield
BIRTHPLACE Trayfen Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 471-10-0917

17. INFORMANT'S OWN SIGNATURE Idaho T.B. Hosp. Records / K. Tyler, MD
ADDRESS Goodding

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Far advanced Pul TBC. — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cor Pulmonale & Jaundice. — 4 days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-2, 1967, *to* 12-15, 1967, *that I last saw the deceased alive on* 12-14, 1967, *and that death occurred at* 2:30 Am., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) K. A. Tyler MD 598

23b. ADDRESS Idaho T.B. Hosp. Goodding

23c. DATE SIGNED 12-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-18-67

24c. NAME OF CEMETERY OR CREMATORY Orofino Cemetery

24d. LOCATION (City, town, or county) (State) Orofino Clearwater Idaho

DATE REC'D BY LOCAL REG. DEC. 15, 1967

REGISTRAR'S SIGNATURE Robert O Meyer

25. FUNERAL DIRECTOR Robert O Meyer — **ADDRESS** Goodding
Thompson Chapel — C-476

Federal Security Agency
United States Public Health Service

Form DPH-49021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 8 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5501
Local Reg. No. 3016
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240 — 1-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wendell 83355
c. LENGTH OF STAY (in this place): 17 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Wendell Manor 339

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Eden 83325
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Lillian
b. (Middle):
c. (Last): Reynolds

4. DATE OF DEATH (Month) (Day) (Year): Dec. 19, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Feb. 28, 1878
9. AGE (In years last birthday): 89 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Whiteville, North Carolina
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John W. Council — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Powell — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE / ADDRESS: X Mrs Owen Hammond / Box 222 Eden, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Old age — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Emaciation — 2 yrs.
DUE TO (c): Arteriosclerosis — 10 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*
Kyphosis — 5 yrs.
Cataracts — 5 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-12, 1966, *to* death, 19__, *that I last saw the deceased alive on* Dec 4, 1967, *and that death occurred at* 1 45 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Harold G. Holsinger M.D. 240
23b. ADDRESS: Wendell, Idaho
23c. DATE SIGNED: 12/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 30, 1967
REGISTRAR'S SIGNATURE: Robert S. Moyer
25. EMBALMER: [signature]
LICENSE NO.: 343

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: White Mortuary 733-6600

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5502
Local Reg. No. 3015
Reg. Dist. No. 420

Certificate of Death

RECEIVED
DEC 26 1967
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Gooding 240 — 2-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Gooding
c. LENGTH OF STAY (If this place): 5 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho T.B. & Chest Disease Hosp. 091

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Payette 380
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Payette
d. STREET ADDRESS (If rural, give location): Box 496

3. NAME OF DECEASED (Type or Print)
a. (First): Guy
b. (Middle): Hobert
c. (Last): Whaley

4. DATE OF DEATH (Month) (Day) (Year): 12-22-67

5. SEX: M.
6. COLOR OR RACE: W
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 7-27-96
9. AGE (In years last birthday): 71 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cafe operator & carpenter
10b. KIND OF BUSINESS OR INDUSTRY: Cafe 26
11. BIRTHPLACE (State or foreign country): North Platte, Nebraska
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: De Witt Whaley — BIRTHPLACE: Glascow, Kentucky
14. MOTHER'S MAIDEN NAME: Dora Becker — BIRTHPLACE: Madison, Wis.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): 7-17 & 1-19 WW #13
16. SOCIAL SECURITY NO.: 508-09-0327
17. INFORMANT'S OWN SIGNATURE: Idaho T.B. Hosp. Records — ADDRESS: K.A. Tyler M.D.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

0021

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Pul. Fibrosis & emphysema — months
DUE TO (c): Far adv. Pul. T.B. — "

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Bronchial obstructive Lung Disease — "

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7-24, 1967, *to* 12-22, 1967, *that I last saw the deceased alive on* 12-21, 1967, *and that death occurred at* 4:50 A *m., from the causes and on the date stated above.*

23a. SIGNATURE: K.A. Tyler M.D. 598 (Degree or title)
23b. ADDRESS: Idaho T.B. Hosp. Gooding
23c. DATE SIGNED: 12-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-27-67
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Payett, Idaho

DATE REC'D BY LOCAL REG.: 12-22-67
REGISTRAR'S SIGNATURE: Robert S. Meyer
25. EMBALMER: Robert S. Meyer
LICENSE NO.: E-424

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Thomason Chapel - Gooding, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 3 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5503
Local Reg. No. 76
Reg. Dist. No. 240

BIRTH NO.

RECEIVED
DEC 26 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
c. LENGTH OF STAY (in this place): 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Grangeville General Hospital

3-02
092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
d. STREET ADDRESS (If rural, give location): East 302 North Second

3. NAME OF DECEASED (Type or Print): a. (First) GEORGE b. (Middle) WILLIAM c. (Last) JORDAN

4. DATE OF DEATH: (Month) November (Day) 28, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: August 27, 1897

9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bookkeeper 19

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Reardan, Washington

12. CITIZEN OF WHAT COUNTRY?: U. S.

13. FATHER'S NAME: Benjamin Jordan — BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Mary Hamilton — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW #1

16. SOCIAL SECURITY NO.: 518 03 5398

17. INFORMANT'S OWN SIGNATURE: Neal Jordan — ADDRESS: Grangeville, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Ruptured aneurysm abdom. aorta — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Generalized arteriosclerosis — several years

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
aneurysm of heart (ascending) — several years
Emphysema — several years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* about [illegible], 19[illegible], *to* 28 Nov, 1967, *that I last saw the deceased alive on* 28 Nov, 1967, *and that death occurred at* [illegible] *m., from the causes and on the date stated above.*

23a. SIGNATURE: Donald Waltman 487 (Degree or title): M.D.

23b. ADDRESS: Grangeville, Idaho

23c. DATE SIGNED: 2 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 1, 1967

24c. NAME OF CEMETERY OR CREMATORY: Prairieview

24d. LOCATION (City, town, or county) (State): Grangeville, Idaho

DATE REC'D BY LOCAL REG.: Dec 18 1967

REGISTRAR'S SIGNATURE: Lima Cone

25. EMBALMER: [illegible]

LICENSE NO.: E 433

FIRM NAME: [illegible]

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES; Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. ~~In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5504
Local Reg. No. 77
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH 250
a. COUNTY Idaho DEC 26 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
c. LENGTH OF STAY (in this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) Trailer House

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Nan	H.	Brust	29 November 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	4 October 1900	67				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Teacher 12	Education	Cloverland, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Fields Mack Halsey	Virginia	Ida Parsons	No. Car.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	541 46 9626	George H. Brust	Grangeville, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Thrombosis, R., Ac. — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Recent Spine Fx.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 26 Nov. 1967 *to* 29 Nov. 1967, *that I last saw the deceased alive on* 29 Nov., 1967, *and that death occurred at* 6:45 ~~7:30~~ PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Milton H. Wilcox M.D. 621	Grangeville Idaho	8 Dec. 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	29 Nov 1967	Lewis-Clark Memo. Gard.	Lewiston, NezPerce Co., Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19 1967	Irma Cone	L.E.DeBaun Malcom's Brower-Wann Memorial Chapel	E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

OCT 13 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 26 1967 Bureau of Vital Statistics

State File No. 5505
Local Reg. No. 78
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 250 Idaho 3-03
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 092 Grangeville General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 310 Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kamiah
d. STREET ADDRESS (If rural, give location): Kamiah, Idaho

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	CHARLES	FRANKLIN	MASON	December 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	July 1 1881	86		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Farming	Colfax, Washington	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John W. Mason	Maryland	Sarah Jane Logsdon	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 03 7460	Mildred Chase	Kamiah, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 491.8 Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: few days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Chronic glomerulonephritis Diabetes mellitus

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	

22. *I hereby certify that I attended the deceased from* 5 Dec, 1967, *to* 7 Dec, 1967, *that I last saw the deceased alive on* 7 Dec, 1967, *and that death occurred at* 6:10 P m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Donald Feltman	487 M.D.	Grangeville, Idaho	8 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/11/1967	Kamiah	Kamiah, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 20, 1967	Irma Cone	Robert R Hansen Robert R Hansen	E 433

FIRM NAME: Robertson-Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5506
Local Reg. No. 17
Reg. Dist. No. 242

Certificate of Death

STATE OF IDAHO

RECEIVED
JAN 12 1968
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH 250
a. COUNTY: Idaho 2-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood
c. LENGTH OF STAY (in this place): 3 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Mary's Hospital 093

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 300 Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Winchester
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Ann
b. (Middle): U.
c. (Last): Kilgore

4. DATE OF DEATH (Month) (Day) (Year): Dec 18 67

5. SEX: F
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Apr 8 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: James Rush — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Liza Smith — BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 60 7588
17. INFORMANT'S OWN SIGNATURE: Hospital Records — ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Hemorrhage	5 weeks
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arterio Sclerotic Heart Disease	10 yrs
DUE TO (c)	Osteo Arthritis	10 yrs
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Osteoporosis	8 yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-22, 1967, *to* 12-18, 1967, *that I last saw the deceased alive on* 12-18, 1967, *and that death occurred at* 12:45a *m., from the causes and on the date stated above.*

23a. SIGNATURE: K. H. Collins 100 (Degree or title): MD
23b. ADDRESS: Craigmont Ida.
23c. DATE SIGNED: 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12 21 67
24c. NAME OF CEMETERY OR CREMATORY: I O O F
24d. LOCATION (City, town, or county) (State): Craigmont, Idaho

DATE REC'D BY LOCAL REG.: Dec 22, 1967
REGISTRAR'S SIGNATURE: Wesley F. Orr, M.D. by TN
25. EMBALMER: Clifford Uhlorn
LICENSE NO.: E 421

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Uhlorn Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5507
Local Reg. No. 1
Reg. Dist. No. 240

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riggins
c. LENGTH OF STAY (in this place): 1-00 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home in Riggins 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Riggins
d. STREET ADDRESS (If rural, give location): Riggins, Idaho

3. NAME OF DECEASED (Type or Print): a. (First) OSCAR b. (Middle) c. (Last) LIEN

4. DATE OF DEATH (Month) (Day) (Year): December 20, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 0

8. DATE OF BIRTH: April 22, 1883

9. AGE (In years last birthday): 84 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Miner 07

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Bjugn Nowray

12. CITIZEN OF WHAT COUNTRY? Norway

13. FATHER'S NAME: Unknown BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME: Unknown BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 518 16 1934

17. INFORMANT'S OWN SIGNATURE: Robert Hansen Dt A Information ADDRESS: Grangeville Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Death from Natural Causes — INTERVAL BETWEEN ONSET AND DEATH: instt

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 4.00p m., from the causes and on the date stated above.*

23a. SIGNATURE: Wm Morrison, M.D. 373 (Degree or title)

23b. ADDRESS: Grangeville, Id.

23c. DATE SIGNED: Dec 26, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/23/67

24c. NAME OF CEMETERY OR CREMATORY: Riggins

24d. LOCATION (City, town, or county) (State): Riggins, Idaho

DATE REC'D BY LOCAL REG.: Jan. 2, 1968

REGISTRAR'S SIGNATURE: Irma Cone

25. EMBALMER: R Hansen Robert R Hansen

LICENSE NO.: E 433

FIRM NAME: Robertson-Hansen funeral home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician Dead on Arrival at Grangeville Clinic. Pt. suddenly collapsed and died while in a Riggins Store.

W. Mannion, M.D

Certificate of Death

STATE OF IDAHO

State File No. 5508
Local Reg. No. 4
Reg. Dist. No. 240

RECEIVED JAN 15 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Idaho 250
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
LENGTH OF STAY (in this place) one week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Grangeville General Hospital 092

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
d. STREET ADDRESS (If rural, give location) 702 South Hall Street

3. NAME OF DECEASED (Type or Print) a. (First) LOIS b. (Middle) F. c. (Last) GILKESON

4. DATE OF DEATH (Month) (Day) (Year) December 26, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH January 9, 1877
9. AGE (In years last birthday) 90
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Salt Springs, Missouri
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jesse Polk Fulkerson
BIRTHPLACE Salt Springs, Missouri
14. MOTHER'S MAIDEN NAME Mary Jane McClelland
BIRTHPLACE Holmes County, Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 54 2324 518 03 5416 D
17. INFORMANT'S OWN SIGNATURE Robert P Hansen Funeral Records
ADDRESS Grangeville, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 3-4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Congestive heart failure — several days
DUE TO (c) arteriosclerotic heart dis. — several years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* about 1961, *to* 26 Dec 1967, *that I last saw the deceased alive on* 26 Dec 1967, *and that death occurred at* 8:15 PM m., *from the causes and on the date stated above.*

23a. SIGNATURE Donald Eltman M.D. 487 (Degree or title)
23b. ADDRESS Grangeville, Idaho
23c. DATE SIGNED 5 Jan 68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/29/1967
24c. NAME OF CEMETERY OR CREMATORY Prairieview
24d. LOCATION (City, town, or county) (State) Grangeville, Idaho

DATE REC'D BY LOCAL REG. Jan. 12, 1968
REGISTRAR'S SIGNATURE Irma Cone
25. EMBALMER Robert R Hansen Robert P Hansen
LICENSE NO. E 433

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: robertson-hansen funeral home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 17 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5509
Local Reg. No. 11
Reg. Dist. No. 240

BIRTH NO.

RECEIVED JAN 22 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Idaho 250 1-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Grangeville
LENGTH OF STAY (in this place): 1/2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Idaho County Nursing Home 276

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Idaho 250
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Cottonwood rural
d. STREET ADDRESS (If rural, give location): 9 mi S

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Marcel	P.	Warren	Dec	28	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	married	Jan 25 1882	85				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Upholstery 21	Auto	Dayton Washington	U S

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Elbert Warren	unknown		unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		518 03 2025 A	Mela C Warren	Whitebird

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Chronic Pyelonephritis — INTERVAL BETWEEN ONSET AND DEATH: several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* ____, 19__, *to* 28 Dec, 1967, *that I last saw the deceased alive on* 27 Dec, 1967, *and that death occurred at* 6:10 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Darrell Allison 487	M.D.	Grangeville, Idaho	12 Jan 68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 30	Community	Cottonwood Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 18 1968	Irma Cone	Clint Uhlorn	E 421

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Uhlorn Funeral Home

MAR 4 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5510
Local Reg. No. 2
Reg. Dist. No. 240

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 250 Idaho JAN 15 1968 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Grangeville
c. LENGTH OF STAY (In this place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Parkhill Manor Nursing Home 331

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cottonwood
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Walter b. (Middle) c. (Last) Summers

4. DATE OF DEATH (Month) Dec (Day) 29 (Year) 67

5. SEX M

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3 Married

8. DATE OF BIRTH March 29 1880

9. AGE (In years last birthday) 87 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) La Grange, Missouri

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Washington Summers — BIRTHPLACE unknown

14. MOTHER'S MAIDEN NAME — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 60 7699

17. INFORMANT'S OWN SIGNATURE Cleo C Robinson — ADDRESS Cottonwood, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart disease unkn.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan, 1967, *to* Dec 29, 1967, *that I last saw the deceased alive on* Dec 28, 1967, *and that death occurred at* 8:50 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Wm C Morrison, M.D. 373 (Degree or title)

23b. ADDRESS Grangeville, Id.

23c. DATE SIGNED Jan 6, 1968

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Jan 2 68

24c. NAME OF CEMETERY OR CREMATORY Community

24d. LOCATION (City, town, or county) Cottonwood (State) Idaho

DATE REC'D BY LOCAL REG. Jan. 9, 1968

REGISTRAR'S SIGNATURE Irma Cone

25. EMBALMER Clint Holborn

LICENSE NO. E 421

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5511
Local Reg. No. 77
Reg. Dist. No. 640

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jefferson 260 — JAN 3 1968 — 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give V.S. Dist. No.): Rural Clark — Bureau of Vital Statistics — c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carson Nursing Home 097

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: 260 Jefferson
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Rigby
d. STREET ADDRESS (If rural, give location): Rt. 2.

3. NAME OF DECEASED (Type or Print): a. (First) JOHN — b. (Middle) OMER — c. (Last) CALL

4. DATE OF DEATH (Month) (Day) (Year): December 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Widowed	March 16, 1887	80		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 054	Farm	Rigby, Idaho	U.S.A.

13. FATHER'S NAME — BIRTHPLACE	14. MOTHER'S MAIDEN NAME — BIRTHPLACE
Cyril Josiah Call. Willard, Utah	Mary Ellen Wood, Willard, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE — ADDRESS
No	518-28-4029	Donna Call Hulleson

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Embolism	Sudden
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease	Years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Previous Stroke + Diabetes Mellitus	2 years Years

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	None performed	YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 10/29, 1967, *to* Dec. 8, 1967, *that I last saw the deceased alive on* Dec. 8, 1967, *and that death occurred at* 5:55P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Osael Call 529	M.D.	Rigby, Idaho	12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 12, 1967	Pioneer	Rigby, Jefferson, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/12/67	Mrs A B Eckersell	A. B. Eckersell	E236

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Eckersell Memorial Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

MAR 20 1981

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5512
Local Reg. No. 75
Reg. Dist. No. 6440

BIRTH NO.

RECEIVED JAN 9 - 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jefferson 260
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rigby
LENGTH OF STAY (in this place): 4 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Carson Nursing Home 097

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 101 Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 2815 Holly Place

3. NAME OF DECEASED (Type or Print): a. (First) Anna b. (Middle) Sara c. (Last) Tewell

4. DATE OF DEATH: December 27 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: November 8, 1890

9. AGE (In years last birthday): 77 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Rouse, Colorado

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Arnold Jaap
BIRTHPLACE: Scotland

14. MOTHER'S MAIDEN NAME: Sara Childs
BIRTHPLACE: England

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519 36 0958

17. INFORMANT'S OWN SIGNATURE: Mrs C.M. Slanski ADDRESS: Idaho Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4209

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — years
DUE TO (c) Generalized Arteriosclerosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Previous fractures both hips — 1 year

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION: Non Performed

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 21 Aug., 1967, *to* 27 Dec., 1967, *that I last saw the deceased alive on* 27 Dec., 1967, *and that death occurred at* 10: m., *from the causes and on the date stated above.*

23a. SIGNATURE: 522 Asael Tall, M.D. (Degree or title)

23b. ADDRESS: Rigby, Idaho

23c. DATE SIGNED: 12-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12/30/67

24c. NAME OF CEMETERY OR CREMATORY: Canyon Hill Cemetery

24d. LOCATION (City, town, or county) (State): Caldwell Idaho

DATE REC'D BY LOCAL REG.: 12/30/67

REGISTRAR'S SIGNATURE: Mrs A B Cockerell

25. EMBALMER: Ralph M. Wood Ralph M. Wood LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5513
Local Reg. No. 1053
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

BIRTH NO. DEC 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton rural
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home Route # 1 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): rural Hazelton 83335
d. STREET ADDRESS (If rural, give location): Route # 1

3. NAME OF DECEASED (Type or Print)
a. (First): Ruthie
b. (Middle): Lunola
c. (Last): Pool

4. DATE OF DEATH (Month) (Day) (Year): December 4,1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: August 8,1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Pike, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: James Alva McDonald — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Sarah Doresa Nicholson — BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-42-5650
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Burley, Idaho
X Mrs Chas Gummerson

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage — 331X

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Ot Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 30 min
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Jerome, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* none, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): R. M. Weber, M.D. Coroner 583
23b. ADDRESS: Jerome, Ida 83338
23c. DATE SIGNED: 6 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec.8,1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec. 11, 1967
REGISTRAR'S SIGNATURE: Louella M Scherer
25. EMBALMER: Ronald J. Hamilton — LICENSE NO.: E-470
FIRM NAME: White Mortuary 733-0600

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 15 1967

Certificate of Death

STATE OF IDAHO

State File No. 5514
Local Reg. No. 1057
Reg. Dist. No. 440

X
BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270 1-00 (Bureau)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton 83335
c. LENGTH OF STAY (in this place): years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Brooks Ave 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hazelton 83335
d. STREET ADDRESS (If rural, give location): Brooks Ave

3. NAME OF DECEASED (Type or Print): a. (First) ROY b. (Middle) FRANCIS c. (Last) BROOKS

4. DATE OF DEATH (Month) (Day) (Year): December 6, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed
8. DATE OF BIRTH: May 11, 1901
9. AGE (In years last birthday): 66 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Handyman, Retired USMC
10b. KIND OF BUSINESS OR INDUSTRY: 05
11. BIRTHPLACE (State or foreign country): Craigmont, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.

13. FATHER'S NAME: Seneber S. Brooks — BIRTHPLACE: PilotRock, Oregon
14. MOTHER'S MAIDEN NAME: Alwilda Victoria Forgey — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes, give war or dates of service): WW2
16. SOCIAL SECURITY NO.: 545-38-7258
17. INFORMANT'S OWN SIGNATURE: X Clark F Brooks — ADDRESS: Hazelton, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 15min

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 6, 1967, *to* Dec. 6, 1967, *that I last saw the deceased alive on* ____, 19____, *and that death occurred at* 1:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Jon D. Wilmoth, M.D.
23b. ADDRESS: Jerome, Idaho
23c. DATE SIGNED: 12.8.67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec.11,1967
24c. NAME OF CEMETERY OR CREMATORY: Hazelton Cemetery
24d. LOCATION (City, town, or county) (State): Jerome county, Idaho

DATE REC'D BY LOCAL REG.: Dec. 14 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: Russell D. Mikel — LICENSE NO.: E-520
FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5515
Local Reg. No. 1054
Reg. Dist. No. 440

RECEIVED

Certificate of Death

STATE OF IDAHO

BIRTH NO.

DEC 15 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict's Nursing Home 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 219 East Ave. "G"

3. NAME OF DECEASED (Type or Print)
a. (First): CHARLOTTE
b. (Middle):
c. (Last): DRISCOLL

4. DATE OF DEATH (Month) (Day) (Year): Dec. 7, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Apr. 15, 1887
9. AGE (In years last birthday): 80 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Homemaker 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): St. Francis, Minnesota
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Semour Miller — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Florence Clements — BIRTHPLACE: Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518 30 1495 BX
17. INFORMANT'S OWN SIGNATURE: Edna Rupert — ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

442X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Senility — INTERVAL BETWEEN ONSET AND DEATH: yrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Generalized C.V.R. disease — yrs.

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Jerome Ida
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1960, *to* 7 Dec, 1967, *that I last saw the deceased alive on* 6 Dec, 1967, *and that death occurred at* 4:20A *m., from the causes and on the date stated above.*

23a. SIGNATURE: L. M. Neher, Cal. 385 (Degree or title)
23b. ADDRESS: Jerome Ida
23c. DATE SIGNED: 9 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Jerome Cemetery
24d. LOCATION (City, town, or county) (State): Jerome, Idaho

DATE REC'D BY LOCAL REG.: Dec. 12, 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-43[illegible]

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 1 5 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5516
Local Reg. No. 1056
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) 1000 North Davis

3. NAME OF DECEASED (Type or Print): a. (First) RONALD b. (Middle) WAYNE c. (Last) FLEMING

4. DATE OF DEATH (Month) (Day) (Year): Dec. 7, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3: Married
8. DATE OF BIRTH: Feb. 24, 1913
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer (ret) 04
10b. KIND OF BUSINESS OR INDUSTRY: Agriculture
11. BIRTHPLACE (State or foreign country): Canton, Oklahoma
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Donald B. Fleming — BIRTHPLACE: Nebraska
14. MOTHER'S MAIDEN NAME: Charlotte Bassford — BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 40 9753
17. INFORMANT'S OWN SIGNATURE: Mrs. Flora Fleming — ADDRESS: Jerome, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).
This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary thrombosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pulmonary edema terminal 1/2 day

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12/4, 1967, *to* 12/7, 1967, *that I last saw the deceased alive on* 12/7, 1967, *and that death occurred at* 8:30 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. L. Hove 476 (Degree or title) MD
23b. ADDRESS: Jerome, Idaho
23c. DATE SIGNED: 12/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 11, 1967
24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.: Dec. 12 1967
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

FIRM NAME: Hove Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DEC 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED DEC 1 5 1967 STATE OF IDAHO

State File No. 5517
Local Reg. No. 1055
Reg. Dist. No. 440

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 413 East Ave. "C" 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
d. STREET ADDRESS (If rural, give location): 413 East Ave. "C"

3. NAME OF DECEASED (Type or Print): a. (First) LEONARD b. (Middle) SHERMAN c. (Last) BOYD

4. DATE OF DEATH (Month) (Day) (Year): Dec. 7, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	May 15, 1912	55		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Hvy. Eqpt. Opr.	County Highway	Jerome, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Dan Boyd	no record	Nancy Sutton	Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518 14 5726	X Shirley L. Boyd	Jerome, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 5 hours

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Angina pectoris & hypertension — 7 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1952, 19___, *to* 12/7/67, 19___, *that I last saw the deceased alive on* 12/7/67, 19___, *and that death occurred at* 3:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
M. Carlyle Smail	MD	Jerome, Idaho	12/9/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 12, 1967	Jerome Cemetery	Jerome, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 12 1967	Loweda M. Scherer	W. L. Hove	E-431

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Hove Funeral Chapel

DEC 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 20 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5518
Local Reg. No. 1058
Reg. Dist. No. 440

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Nursing Home 098

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Jerome 270
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome
d. STREET ADDRESS (If rural, give location) 511 West Ave. "C"

3. NAME OF DECEASED (Type or Print) a. (First) CHRISTINA b. (Middle) KATHERINE c. (Last) STRICKER

4. DATE OF DEATH (Month) (Day) (Year) Dec. 10, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed
8. DATE OF BIRTH Jan. 21, 1900
9. AGE (In years last birthday) 67 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Norka, Russia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry Kaiser BIRTHPLACE Russia
14. MOTHER'S MAIDEN NAME Mollie Schliening BIRTHPLACE Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 32 6507
17. INFORMANT'S OWN SIGNATURE X Mrs A. L. Bateman ADDRESS Jerome, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH 1 wk.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) parkinsonsdisease — 3 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility & Inanition — 6 mo

350X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Feb 7, 1955, *to* Dec 10, 1967, *that I last saw the deceased alive on* Dec 10, 1967, *and that death occurred at* 10:30P m., *from the causes and on the date stated above.*

23a. SIGNATURE James E. Moan 476 (Degree or title) M.D.
23b. ADDRESS Jerome Ida
23c. DATE SIGNED 12/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 14, 1967
24c. NAME OF CEMETERY OR CREMATORY Jerome Cemetery
24d. LOCATION (City, town, or county) Jerome, Idaho (State)

DATE RECD BY LOCAL REG. Dec. 15 1967
REGISTRAR'S SIGNATURE Louella M. Deluer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5519
Local Reg. No. 1059
Reg. Dist. No. 440

RECEIVED DEC 2 1 1967 Bureau of Health

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270 3-43
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
c. LENGTH OF STAY (in this place): 13 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedicts Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 320 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Richfiled 83349
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
IDA	E.	LEMMON	Dec.	13,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married	Jan. 5, 1879	88	11	8		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	home	Benton, Kansas	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Emery Sharp	New York	Ella Hitchkock	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	No	519-14-9762B	Clarence Lemmon	Richfield, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

331X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Cerebro-vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 2 wks

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 30, 1967, *to* Dec 13, 1967, *that I last saw the deceased alive on* Dec 13, 1967, *and that death occurred at* 11:45A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 385		Box 68 Shoshone Idaho 83352	Dec 19 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-16-67	Richfield Cemetery	Richfield, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19, 1967	Lowella M. Dahrer	Francis M. Bergin	E-463

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bergin Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 7 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 22 1974

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5520
Local Reg. No. 1060
Reg. Dist. No. 440

Certificate of Death

BIRTH NO. RECEIVED STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY Jerome 270 JAN 4 1968 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give TOWNSHIP) Jerome Bureau of Vital Statistics
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Benedict's Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 270 Jerome
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Jerome 83338
d. STREET ADDRESS (If rural, give location) 400 3rd. Ave. East

3. NAME OF DECEASED (Type or Print)
a. (First) Margaret
b. (Middle) Elizabeth
c. (Last) McManus

4. DATE OF DEATH (Month) (Day) (Year) Dec. 27, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 30, 1883
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY at home
11. BIRTHPLACE (State or foreign country) Co. Londonderry, Ireland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME James Hogg — BIRTHPLACE Ireland
14. MOTHER'S MAIDEN NAME Matilda Gilmore — BIRTHPLACE Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518 60 3607
17. INFORMANT'S OWN SIGNATURE X Charles McManus Jr. — ADDRESS Seattle, Wn.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Terminal cardiac failure — INTERVAL BETWEEN ONSET AND DEATH 1 day

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Senility & Inanition — yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-13-, 1967, *to* 12-27-, 1967, *that I last saw the deceased alive on* 12-27-, 1967, *and that death occurred at* 10:10 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE 385 L. M. Leber, M.D. (Degree or title)
23b. ADDRESS Jerome
23c. DATE SIGNED 30 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) Twin Falls, Idaho (State) 83301

DATE REC'D BY LOCAL REG. Jan. 2, 1968
REGISTRAR'S SIGNATURE Louella M. Scherer
25. EMBALMER W. L. Hove
LICENSE NO. E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 5 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5521
Local Reg. No. 1062
Reg. Dist. No. 440

RECEIVED JAN 4 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome 83338
LENGTH OF STAY (in this place): 8 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Benedict Hospital 099

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 320 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dietrich Rural 83324
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) VICENTE b. (Middle) c. (Last) GUISASOLA

4. DATE OF DEATH: (Month) Dec. (Day) 28, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced
8. DATE OF BIRTH: Feb. 26, 1885
9. AGE (In years last birthday): 82 IF UNDER 1 YEAR Months: 10 Days: 2 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Acordia, Viscaya, Spain
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown BIRTHPLACE: Spain
14. MOTHER'S MAIDEN NAME: Unknown BIRTHPLACE: Spain

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: 518-20-1279A
17. INFORMANT'S OWN SIGNATURE: Modesto V Guisasola ADDRESS: Dietrich, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 442X Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 10 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular Renal Disease — 3 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 3, 1966, to Dec 28, 1967, that I last saw the deceased alive on Dec 28, 1967, and that death occurred at 3:20 m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] 385 (Degree or title)
23b. ADDRESS: Box 68 Shoshone Idaho 83352
23c. DATE SIGNED: 12-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-3-1968
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: Jan. 3 1968
REGISTRAR'S SIGNATURE: Louella M. Osburn
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463
FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES: JAN 5 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5522
Local Reg. No. 1061
Reg. Dist. No. 440

Certificate of Death

STATE OF IDAHO

RECEIVED
JAN 4 1968
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Jerome 270 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Jerome (rural) 83338
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hwy # 80 just East of Hwy #93 interchange 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 45 Utah
b. COUNTY: 555 Salt Lake
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Murray
d. STREET ADDRESS (If rural, give location): 175 East 4800 South

3. NAME OF DECEASED (Type or Print)
a. (First): KATHY
b. (Middle): LOUISE
c. (Last): ROOT

4. DATE OF DEATH (Month) (Day) (Year): Dec. 29, 1967

5. SEX: Female
6. COLOR OR RACE: Caucasian
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never married
8. DATE OF BIRTH: Dec. 2, 1954
9. AGE (In years last birthday): 13 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY: Junior High
11. BIRTHPLACE (State or foreign country): El Paso, Texas
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: William Root — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Maxine Long — BIRTHPLACE: Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: --
17. INFORMANT'S OWN SIGNATURE: X Mrs. Marie Vancil 91744 — ADDRESS: La Puente, Calif.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8224

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Fractured neck — INTERVAL BETWEEN ONSET AND DEATH: nil

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ~~ACCIDENT~~ ~~SUICIDE~~ ~~HOMICIDE~~ (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Hiway 80 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 270 (STATE): 13 Jerome Ida
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): m. 0
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: Tire blew - Car rolled

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 1:15 p.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): 385 K. Weber, M.D. Coroner
23b. ADDRESS: Jerome
23c. DATE SIGNED: 2 Jan 68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Jan. 3, 1968
24c. NAME OF CEMETERY OR CREMATORY: Mount Calvary Cemetery
24d. LOCATION (City, town, or county) (State): Salt Lake Co., Utah

DATE REC'D BY LOCAL REG.: Jan. 2 1968
REGISTRAR'S SIGNATURE: Louella M. Scherer
25. EMBALMER: W. L. Hove
LICENSE NO.: E-431

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Hove Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 5 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5523
Local Reg. No. 263
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JAN 8 1968 Vital Statistics Bureau of

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Dalton Gardens 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 06 Colorado
b. COUNTY: 555 Boulder
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boulder
d. STREET ADDRESS (If rural, give location): 1321 Baesam

3. NAME OF DECEASED (Type or Print): a. (First) Altee b. (Middle) E c. (Last) Dehn

4. DATE OF DEATH: (Month) 11 (Day) 15 (Year) 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: 11-29-1906

9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sales Lady 25

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Boulder Colo

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Jacob M Allen — BIRTHPLACE: Colo

14. MOTHER'S MAIDEN NAME: Hattie August — BIRTHPLACE: Colo

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): none — (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 512 32 2011

17. INFORMANT'S OWN SIGNATURE: Mrs. Betty Grow — ADDRESS: CdA. Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

163X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory failure — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) carcinoma lung — months

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-1, 1967, *to* 11-15, 1967, *that I last saw the deceased alive on* 11-15, 1967, *and that death occurred at* 3p m., *from the causes and on the date stated above.*

23a. SIGNATURE: Allen M. Parham M.D. 622 (Degree or title)

23b. ADDRESS: Hayden Lake Idaho

23c. DATE SIGNED: 1-4-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: 11-16-67

24c. NAME OF CEMETERY OR CREMATORY:

24d. LOCATION (City, town, or county) (State): Boulder Colo

DATE REC'D BY LOCAL REG.: Jan. 4, 1968

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland — LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5524
Local Reg. No. 272
Reg. Dist. No. 120

RECEIVED JAN 15 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN: Coeur d' Alene
c. STAX (in this place): 6 dyas
d. FULL NAME OF HOSPITAL OR INSTITUTION: Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 13
b. COUNTY: Kootenai 281
c. CITY OR TOWN: Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 503 Best

3. NAME OF DECEASED (Type or Print)
a. (First): John
b. (Middle): 101
c. (Last): Aresvik

4. DATE OF DEATH (Month) (Day) (Year): December 31, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: April 25, 1893

9. AGE (In years last birthday): 74
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant 22

10b. KIND OF BUSINESS OR INDUSTRY: Own Store

11. BIRTHPLACE (State or foreign country): Norway

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jacob Aresvik
BIRTHPLACE: Norway

14. MOTHER'S MAIDEN NAME: Marie(not obtainable)
BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): W.W. I

16. SOCIAL SECURITY NO.: 519-36-2926

17. INFORMANT'S OWN SIGNATURE: A Lawrence Aresvik
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): arteriosclerosis — years
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-26-, 1967, *to* 12-31-, 1967, *that I last saw the deceased alive on* 12-31-, 1967 *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Allen M. Fenhem M.D. 622

23b. ADDRESS: Hayden Lake, Idaho

23c. DATE SIGNED: 1-5-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 1-3-1968

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Jan. 9, 1968

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Bill Duff

LICENSE NO.: E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5525
Local Reg. No. 371
Reg. Dist. No. 120

RECEIVED
JAN 1 5 1968
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 2 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 502 2nd. St.

3. NAME OF DECEASED (Type or Print) a. (First) Mildred b. (Middle) Ann c. (Last) Anderson

4. DATE OF DEATH (Month) (Day) (Year) Nov. 26, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3 Married

8. DATE OF BIRTH 11-30-1897

9. AGE (In years last birthday) 69
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Dallas, Texas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 367-26-8256

17. INFORMANT'S OWN SIGNATURE ADDRESS
Erns Anderson, Coeur d Alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1530

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Adenocarcinoma — INTERVAL BETWEEN ONSET AND DEATH 5 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Adenocarcinoma Ascending Colon

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 10-27-66

19b. MAJOR FINDINGS OF OPERATION Carcinoma right colon

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-15, 1966, *to* 11-26, 1967, *that I last saw the deceased alive on* 11-26, 1967, *and that death occurred at* 10:45 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE C E Thompson 530 (Degree or title) MD

23b. ADDRESS 318 Elder Bldg. Coeur d Alene Idaho

23c. DATE SIGNED 11-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec 2 1967

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. 1-8-68

REGISTRAR'S SIGNATURE Lorraine K. Brewer

25. EMBALMER Fred H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 26 1968

JUL 14 1997

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5526
Local Reg. No. 239
Reg. Dist. No. 120

RECEIVED
DEC 14 1967
Bureau of Vital Statistics

BIRTH NO. 2-03

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
LENGTH OF STAY (in this place): 3 Mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Pinewood Manor 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 607 Front

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Dorathy	May	Kuebler	12	1	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widowed	11-9-1895	72				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Overbrook Kans
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: A.C. Fairchild — BIRTHPLACE: Kantucky
14. MOTHER'S MAIDEN NAME: Armetta Kimble — BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 518 03 6602
17. INFORMANT'S OWN SIGNATURE: D Clyde Fairchild — ADDRESS: Cd A. Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cardiac, Chronic Myocarditis	10 years
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	Pulmonary Congestion	1 mo.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct., 19 62, *to* Dec., 19 67, *that I last saw the deceased alive on* Nov. 30 19 67, *and that death occurred at* 5:30 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: Ross Benson, M.D. 225 (Degree or title)
23b. ADDRESS: Coeur d'Alene Idaho
23c. DATE SIGNED: 12/1/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-4-67
24c. NAME OF CEMETERY OR CREMATORY: Forest
24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Dec. 4, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Fred Noland
LICENSE NO.: E- 493

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Yates Funeral Home

DUTIES:

DEC 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5527
Local Reg. No. 248
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 22 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 1-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 5 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Mem. Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene,
d. STREET ADDRESS (If rural, give location): 404 Fernan Rd.

3. NAME OF DECEASED (Type or Print): a. (First) Anna; b. (Middle) E.; c. (Last) Fedder

4. DATE OF DEATH: (Month) Dec. (Day) 3, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 8-11-1889

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): South Dakota

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: E.B. Brown
BIRTHPLACE: Redfield, Iowa

14. MOTHER'S MAIDEN NAME: Sarah C. Fink
BIRTHPLACE: Redfield, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-10-3971

17. INFORMANT'S OWN SIGNATURE: Mr. William Fedder, Cd'A. Idaho
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cause Undetermined — Probably, acute, massive Coronary occlusion. - D.O.A.

INTERVAL BETWEEN ONSET AND DEATH: Minutes.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* —, 19—, *to* —, 19—, *that I last saw the deceased alive on* —, 19—, *and that death occurred at* 7 Eve P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: Lynn C Fredrickson M.D. 177 (Degree or title)

23b. ADDRESS: Coeur d' Alene, Idaho

23c. DATE SIGNED: 12/12/67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-6-1967

24c. NAME OF CEMETERY OR CREMATORY: Greenwood Cemetery

24d. LOCATION (City, town, or county) (State): Kellogg, Idaho

DATE REC'D BY LOCAL REG.: Dec. 13, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred H. Noland

LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. MAR 2 1970

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5528
Local Reg. No. 251
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 22 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 1-20
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 20 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene,
d. STREET ADDRESS (If rural, give location): 1311 1st. Street

3. NAME OF DECEASED (Type or Print): a. (First) George; b. (Middle) G.; c. (Last) Melton

4. DATE OF DEATH: (Month) Dec. (Day) 4, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 6-7-1883

9. AGE (In years last birthday): 84
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 01

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Chillocothe, Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Henry Nelton
BIRTHPLACE: Tenn.

14. MOTHER'S MAIDEN NAME: Salinda Coberly
BIRTHPLACE: Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 519-60-9750T

17. INFORMANT'S OWN SIGNATURE: Mrs. Pearl Melton, Coeur d'Alene, Id
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cardiac Decompensation — 6 Months
DUE TO (c): Arteriosclerotic cardiovascular renal disease — 20 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10/ *19* 54, *to* 12/4, *19* 67, *that I last saw the deceased alive on* 12/4, *19* 67, *and that death occurred at* 2:45 P *m., from the causes and on the date stated above.*

23a. SIGNATURE H. Don Moseley, M.D. (Degree or title) 375
H. Don Moseley, M.D.

23b. ADDRESS: 421 Coeur d'Alene Ave., Coeur d'Alene

23c. DATE SIGNED: 12/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-7-1967

24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery

24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Dec 14, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred H. Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr. W. Wilson

Certificate of Death

RECEIVED STATE OF IDAHO

State File No. 5529
Local Reg. No. 237
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY KOOTENAI 281 DEC 14 1967 000
b. CITY OR TOWN COEUR D' ALENE (If outside corporate limits, write RURAL and give Township) Bureau of Vital Statistics c. LENGTH OF STAY IN THIS PLACE
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 310-FOREST DRIVE 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE IDAHO b. COUNTY KOOTENAI 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) COEUR D' ALENE
d. STREET ADDRESS (If rural, give location) 310-FOREST DRIVE

3. NAME OF DECEASED (Type or Print) a. (First) MARY b. (Middle) B. c. (Last) DIEDRICK

4. DATE OF DEATH (Month) (Day) (Year) DECEMBER 4, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	WIDOWED	JAN. 21, 1891	76				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
COOK	HOTEL	WISCONSIN	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
MATTHEW BENSON	NORWAY	CARLINA OLSON	NORWAY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO	NONE	518-12-4200	Mrs. John Rheinschmidt	Cd'aIda

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cardiac decompensation	Passed away in sleep.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Congestive heart failure	
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes mellitus	1 year

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Nov 15, 1966, *to* Dec 4, 1967, *that I last saw the deceased alive on* Oct 19, 1967, *and that death occurred at* early a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. Wray Wilson M.D. 568	Coeur d Alene, Idaho	12/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
REMOVAL & BURIAL	12-6-67	LAKEVIEW CEMETERY	SANDPOINT, IDAHO

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 8, 1967	Lorraine K. Brush	M. E. Pickinpaugh	E-397

FIRM NAME: ENGLISH CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5530
Local Reg. No. 238
Reg. Dist. No. 120

RECEIVED DEC 14 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 1 — 3-11
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 11 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28 0
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rathdrum
d. STREET ADDRESS (If rural, give location): Box 64

3. NAME OF DECEASED (Type or Print)
a. (First): Clarence
b. (Middle): D. 101
c. (Last): Howell

4. DATE OF DEATH (Month) (Day) (Year): December 4, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Sept. 6, 1901

9. AGE (In years last birthday): 66
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Woodsman 17

10b. KIND OF BUSINESS OR INDUSTRY: Logging

11. BIRTHPLACE (State or foreign country): Rathdrum, Ida.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Howell
BIRTHPLACE: Ill.

14. MOTHER'S MAIDEN NAME: Elizabeth Linton
BIRTHPLACE: Ill.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): -----
(If yes, give war or dates of service): -----

16. SOCIAL SECURITY NO.: 518-03-6873

17. INFORMANT'S OWN SIGNATURE ADDRESS: X Mrs. Clarence Howell, Rathdrum

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Coronary occlusion, acute, severe — INTERVAL BETWEEN ONSET AND DEATH: 10-11 hours.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1961, 19__, *to* 12/4/67, 19__, *that I last saw the deceased alive on* 12/4/67, 19__, *and that death occurred at* 10:45 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Lynn C. Jacobson MD

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 12/7/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-7-1967

24c. NAME OF CEMETERY OR CREMATORY: Pinegrove Cemetery

24d. LOCATION (City, town, or county) (State): Rathdrum Ida.

DATE REC'D BY LOCAL REG.: Dec. 8, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: D. F. Ripling, Jr.

LICENSE NO.: E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Lee Barclay

RECEIVED DEC 22 1967

Certificate of Death

STATE OF IDAHO

State File No. 5531
Local Reg. No. 247
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 28
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 1720 Lakeside

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Leo	Jacob	Elton	December 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	Married	Feb. 17, 1895	72		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Own Farm	Iowa	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Elton	Not Known	Lottie Green	Not Known

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-01-8988	Mrs Leo E. Elton	Cour d'alene Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Myocardial failure	5 min.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Chronic anemia	2 yr.
DUE TO (c)	Multiple Myeloma	2 yr

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-5, 1965, *to* 12-5, 1967, *that I last saw the deceased alive on* 12-5, 1967, *and that death occurred at* 10 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lee Barclay M.D. 025	Coeur d'Alene, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-9-1967	Restlawn Memorial Pk.	Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec 14 1967	Lorraine K. Brush	N. J. Ryplinger Jr	E-397

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 22 1967

Certificate of Death

STATE OF IDAHO

State File No. 5532
Local Reg. No. 254
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Tubbs Hill

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 914 6th Street

3. NAME OF DECEASED (Type or Print): a. (First) James b. (Middle) Joseph c. (Last) Webb
AKA: James Peter Webb

4. DATE OF DEATH: (Month) (Day) (Year) December 8, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never Married	6-20-1930	37				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Marine & Army 05	Military	Clarks Fork, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Delbert Webb	Kansas	Maybelle English	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes	1947-1965 7	519-28-1254	Keith E. Webb	Coeur d'Alene, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suicide by fire arms — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gunshot wound of head
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21f. HOW DID INJURY OCCUR?
Suicide	Tubbs Hill	Coeur d'alene Kootenai 281 (COUNTY) Idaho (STATE)	m.		Shot himself w a rifle

22. *I hereby certify that I attended the deceased from* Did Not, 19___, to ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
William T. Wood M.D. Coroner 583	Coeur d'Alene, Idaho	12-13-'67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-13-1967	Clarks Fork Cemetery	Clarks Fork Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 13, 1967	Lorraine K. Brush	Bill Wulff	E-439

FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5533
Local Reg. No. 253
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 22 1967 Bureau

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 205 Indiana Avenue

3. NAME OF DECEASED (Type or Print)
a. (First) Knut
b. (Middle) T.
c. (Last) Skoven

4. DATE OF DEATH (Month) Dec. (Day) 9, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH 8-8-1883
9. AGE (In years last birthday) 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Agriculture
11. BIRTHPLACE (State or foreign country) Norway
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Sven Knutsen — BIRTHPLACE Norway
14. MOTHER'S MAIDEN NAME Margit Knutsen — BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 519-60-9751
17. INFORMANT'S OWN SIGNATURE Edward H. Johnson (BD) — ADDRESS Coeur d'Alene, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

593X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Combined cardiac and renal failure with uremia — INTERVAL BETWEEN ONSET AND DEATH 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-5, 1967, *to* 12-9, 1967, *that I last saw the deceased alive on* ____, 19__ *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 251 (Degree or title)
23b. ADDRESS Coeur d'Alene, Idaho
23c. DATE SIGNED 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-14-1967
24c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. Dec. 14, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER [signature] Riplinger Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5534
Local Reg. No. 246
Reg. Dist. No. 120

BIRTH NO.

RECEIVED DEC 22 1967 Bureau of Statistics

1-54

1. PLACE OF DEATH
a. COUNTY Kootenai 280
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spirit Lake
c. LENGTH OF STAY (in this place) 54 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Conklin Resort 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Spirit Lake
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Earl b. (Middle) A. c. (Last) Conklin

4. DATE OF DEATH (Month) Dec. (Day) 11, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH 3-7-1878

9. AGE (In years last birthday) 89 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Painter 21

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Clark, South, Dakota

12. CITIZEN OF WHAT COUNTRY? usa

13. FATHER'S NAME E.F. Conklin
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-60-7596

17. INFORMANT'S OWN SIGNATURE Homer Conklin
ADDRESS Spirit Lk, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Gastric Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 20-30 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Gastric ulcer - Chronic — 5-6 yrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

5400

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1948, 19___, *to* 12/11/67, 19___, *that I last saw the deceased alive on* October, 1967, *and that death occurred at* 1:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE Lynn C. Fredrickson (Degree or title) MD

23b. ADDRESS Coeur d'Alene, Idaho.

23c. DATE SIGNED 12/12/67.

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2

24b. DATE 12-14-1967

24c. NAME OF CEMETERY OR CREMATORY Hazen & Jaeger

24d. LOCATION (City, town, or county) Spokane, Washington (State)

DATE REC'D BY LOCAL REG. Dec. 13, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED DEC 22 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5535
Local Reg. No. 256
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 28 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): D.O.A.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K. M. Hosp 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hayden Lake
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Clarence b. (Middle) O. c. (Last) Helgeson

4. DATE OF DEATH: (Month) 12 (Day) 12 (Year) 67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married

8. DATE OF BIRTH: 6-6-1903

9. AGE (In years last birthday): 64
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Minn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Bertt Helgeson
BIRTHPLACE: Unkown

14. MOTHER'S MAIDEN NAME: Tillie Unkown
BIRTHPLACE: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 701 09 4115

17. INFORMANT'S OWN SIGNATURE: Mrs. Grace Helgeson
ADDRESS: Hayden Lake Id

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable Acute Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE 583 William T. Wood M.D. Coroner (Degree or title)

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 12-16-'67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-16-67

24c. NAME OF CEMETERY OR CREMATORY: Restlawn

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Dec. 18, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland
LICENSE NO.

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 5 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5536
Local Reg. No. 258
Reg. Dist. No. 120

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Rt. 3 Box 373 French Gulch

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Dean	G.	Rehard	Dec. 12 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married	May 13, 1915	52				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Millworker 17	Sawmill	Huntley, Montana	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Wallace Rehard	Iowa	Elsie Rehard McCaw	Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	518-12-9782	LeElla Rehard	Coeur d'Alene, Id

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hepatitis, acute, severe, fatal — INTERVAL BETWEEN ONSET AND DEATH: 6-8 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cirrhosis — ?
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* Dec 12, 1967, *that I last saw the deceased alive on* Dec 11, 1967, *and that death occurred at* 1:20 A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Lynn O. Jackson MD	Coeur d'Alene, Idaho	12/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-15-1967	Forest Cemetery	Coeur d' Alene, Ida.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 22 1967	Lorraine K. Brush	Bill Huff	E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 11 1983

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 22 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5537
Local Reg. No. 245
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 28 1 1-10
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (in this place) 10 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 424 Locust (home) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 28 1 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 424 locust St.

3. NAME OF DECEASED (Type or Print)
a. (First) Fred
b. (Middle)
c. (Last) Banning

4. DATE OF DEATH (Month) Dec. (Day) 12, (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3 Married

8. DATE OF BIRTH 9-9-1892

9. AGE (In years last birthday) 75
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 29

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) Leavenworth, Kan.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Unknown
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 712-05-1955

17. INFORMANT'S OWN SIGNATURE Ruby Banning, ADDRESS Coeur d' Alene, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4201 Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH 1 hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 7, 1967, *to* Dec 12, 1967, *that I last saw the deceased alive on* Dec 12, 1967, *and that death occurred at* 7:15 A m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 796 (Degree or title) MD

23b. ADDRESS Coeur d alene Id

23c. DATE SIGNED 12/14/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-14-1967

24c. NAME OF CEMETERY OR CREMATORY Pinegrove Cemetery

24d. LOCATION (City, town, or county) Rathdrum, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 18, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Fred H. Noland

LICENSE NO. E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 8 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5538
Local Reg. No. 256
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JAN 2 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Terrace Nursing Home 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Post Falls
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Elma b. (Middle) May c. (Last) Hart

4. DATE OF DEATH (Month) (Day) (Year): December 18, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept 22, 1886

9. AGE (In years last birthday): 81 | If UNDER 1 YEAR: Months, Days | If UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own HOme

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Geroge Bates
BIRTHPLACE: Arkansas

14. MOTHER'S MAIDEN NAME: Rosa Kilgore
BIRTHPLACE: Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 519-60-9850

17. INFORMANT'S OWN SIGNATURE: Kathleen M. Wells
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral Thrombosis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Cerebral vascular insuffiency

DUE TO (c): Hypertensive arterio scloertic cardiovascular disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4-16-63, *to* 12-18, 1967, *that I last saw the deceased alive on* 12-15-67 19___, *and that death occurred at* 12:55A m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. T. Culbertson, M.D. 087

23b. ADDRESS: Hayden Lake, Idaho 83835

23c. DATE SIGNED: 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-20-1967

24c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

24d. LOCATION (City, town, or county) (State): Post Falls, Idaho

DATE REC'D BY LOCAL REG.: Dec 26, 1967

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Bill Duff
LICENSE NO.: E-439
FIRM NAME: English Chapel, Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 12 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5539
Local Reg. No. 269
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 8 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place): 48 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Coeur d' Alene Homes 103

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): Coeur d' Alene Homes

3. NAME OF DECEASED (Type or Print)
a. (First): Cora
b. (Middle): AQ
c. (Last): Woelk

4. DATE OF DEATH (Month) (Day) (Year): Dec. 18, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: 1-26-1886
9. AGE (In years last birthday): 81 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Oliver McKinney — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Amendia Diehl — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO
16. SOCIAL SECURITY NO.: 518-01-6481D
17. INFORMANT'S OWN SIGNATURE — ADDRESS: Genevieve Rader, Spokane, Wash.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral hemorrhage

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Cerebral vascular insufficiency
DUE TO (c): Hypertensive arterioaclerotic cardio vascular disease

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-10-, 1964, *to* 12-18-, 1967, *that I last saw the deceased alive on* 12-13-67, 19__, *and that death occurred at* 7:20 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C. J. Cederblom, M.D. 087
23b. ADDRESS: Hayden Lake, Idaho 83835
23c. DATE SIGNED: 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-21-1967
24c. NAME OF CEMETERY OR CREMATORY: Forst Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Dec. 27, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Fred H. Noland — LICENSE NO.: E-493

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 30 1968

FEB 27 1968

APR 4 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5540
Local Reg. No. 257
Reg. Dist. No. 120

Certificate of Death

RECEIVED
JAN 2 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH 280
a. COUNTY Kootenai 1-57
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harrison
c. LENGTH OF STAY (in this place) 57 Yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) At Home 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Harrison
d. STREET ADDRESS (If rural, give location) —

3. NAME OF DECEASED (Type or Print)
a. (First) Giacomo
b. (Middle) —
c. (Last) Luchini

4. DATE OF DEATH (Month) (Day) (Year) Dec. 19 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Dec. 25, 1886
9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman 17
10b. KIND OF BUSINESS OR INDUSTRY Lumber Mills
11. BIRTHPLACE (State or foreign country) Italy
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Angelo Luchini — BIRTHPLACE Italy
14. MOTHER'S MAIDEN NAME Florence Contardo — BIRTHPLACE Italy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-03-3725
17. INFORMANT'S OWN SIGNATURE Maria Luchini — ADDRESS Harrison

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* DOA *19___, to _____, 19___, that I last saw the deceased alive on* 12-19 *, 19*67*, and that death occurred at* 2A *m., from the causes and on the date stated above.*

23a. SIGNATURE B. A. Rapp M.D. 428 (Degree or title)
23b. ADDRESS St. Maries Idaho
23c. DATE SIGNED 12-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 22, 1967
24c. NAME OF CEMETERY OR CREMATORY Harrison
24d. LOCATION (City, town, or county) Harrison (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 21, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Gerald Browning
LICENSE NO. E-411

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Browning Funerah Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAY 27 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 22 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5541
Local Reg. No. 255
Reg. Dist. No. 120

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 081 1-33
b. CITY OR TOWN Coeur d' Alene
c. LENGTH OF STAY (in this place) 33 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hosp. 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) 515 Montana Ave.

3. NAME OF DECEASED (Type or Print) a. (First) Fenimore b. (Middle) c. (Last) Cady

4. DATE OF DEATH (Month) (Day) (Year) Dec. 20, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 3-30-1889

9. AGE (In years last birthday) 78
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumber Broker 24

10b. KIND OF BUSINESS OR INDUSTRY Self (Retired)

11. BIRTHPLACE (State or foreign country) Kyoto, Japan

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Chauncey M. Cady
BIRTHPLACE Mass

14. MOTHER'S MAIDEN NAME Virginia Clarkson
BIRTHPLACE Mass.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 135-03-6862A

17. INFORMANT'S OWN SIGNATURE Mrs. Ruth Cady ADDRESS Coeur d' Alene, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 350X Parkinsonism

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Uremia

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* _____, 19__, *that I last saw the deceased alive on* Dec 20, 1967, *and that death occurred at* 11 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Clarence M. Swanson MD (Degree or title) 192

23b. ADDRESS 808 ash

23c. DATE SIGNED 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE 12-22-1967

24c. NAME OF CEMETERY OR CREMATORY Hazen & Jaeger

24d. LOCATION (City, town, or county) Spokane, (State) Washington

DATE REC'D BY LOCAL REG. Dec. 22, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER Gilbert D. Yates

LICENSE NO. E-365

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 22 1968

APR 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5542
Local Reg. No. 264
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN Coeur d' Alene
LENGTH OF STAY (in this place) 9 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION Pine Wood Manor 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 28
c. CITY OR TOWN Spirit Lake
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Hanna b. (Middle) V. c. (Last) Glad

4. DATE OF DEATH (Month) (Day) (Year) December 20, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH 3-22-1888
9. AGE (In years last birthday) 79 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Sweden
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE ADDRESS Mr. Gurtaf Glad, Spirit Lk. Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

5586X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Obstructive Jaundice — INTERVAL BETWEEN ONSET AND DEATH days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec, 19 64 *to* Dec, 19 67, *that I last saw the deceased alive on* 12-20, 19 67 *and that death occurred at* 10:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE 622 (Degree or title)
23b. ADDRESS Hayden Lake, Idaho
23c. DATE SIGNED 12-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-23-1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood Cemetery
24d. LOCATION (City, town, or county) Spirit Lake, Idaho (State)

DATE REC'D BY LOCAL REG. Dec. 27, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brewer
25. EMBALMER Gilbert D. Yates
LICENSE NO. E-365

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Yates Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5543
Local Reg. No. 259
Reg. Dist. No. 120

RECEIVED JAN 2 1968 Bureau of Vital Statistics STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
c. LENGTH OF STAY (In this place) 18 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d' Alene
d. STREET ADDRESS (If rural, give location) Rt. #3 Box 636

3. NAME OF DECEASED (Type or Print)
a. (First) Albert
b. (Middle) 101
c. (Last) Wang

4. DATE OF DEATH (Month) (Day) (Year) December 21, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 10-1-1898

9. AGE (In years last birthday) 69
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pumper 09

10b. KIND OF BUSINESS OR INDUSTRY Public Utility

11. BIRTHPLACE (State or foreign country) Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Wang
BIRTHPLACE Unobtainable

14. MOTHER'S MAIDEN NAME Lena Dahl
BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 313-18-8364

17. INFORMANT'S OWN SIGNATURE X Mrs Albert Wang
ADDRESS Coeur d'Alene Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Emphysema & Lung
ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Bronchial Pneumonia
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. AS H.D.

INTERVAL BETWEEN ONSET AND DEATH

493 X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-4-67, 19____, *to* present, 19____, *that I last saw the deceased alive on* 12-21-67, 19____, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE 128 (Degree or title)

23b. ADDRESS 816 Sherman, Coeur d'Alene, Ida.

23c. DATE SIGNED 12-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-23-1967

24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery

24d. LOCATION (City, town, or county) (State) Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG. Dec 26, 1967

REGISTRAR'S SIGNATURE Lorraine K. Brush

25. EMBALMER

LICENSE NO. E-439

FIRM NAME: English Chapel-Coeur d'Alene

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under it JAN to 23 1968 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5544
Local Reg. No. 270
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 8 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 280 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 312-3rd, Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location) Box 623

3. NAME OF DECEASED (Type or Print)
a. (First) Edman
b. (Middle) G.
c. (Last) Wynkoop

4. DATE OF DEATH (Month) (Day) (Year) Dec. 22, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 4-2-96
9. AGE (In years last birthday) 71 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister 18
10b. KIND OF BUSINESS OR INDUSTRY Religion
11. BIRTHPLACE (State or foreign country) Kansas
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George Wynkoop — BIRTHPLACE -------
14. MOTHER'S MAIDEN NAME -------- — BIRTHPLACE ------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 520-05-6459
17. INFORMANT'S OWN SIGNATURE Oren Hutchison — ADDRESS Post Falls, Ida

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cause ill defined — INTERVAL BETWEEN ONSET AND DEATH Immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Possible Coronary occlusion.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did not, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE 583 (Degree or title) William T. Wood, M.D. Coroner
23b. ADDRESS Coeur d'Alene Idaho
23c. DATE SIGNED 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-27-1967
24c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery
24d. LOCATION (City, town, or county) (State) Coeur d'Alene, Idaho

DATE REC'D BY LOCAL REG. Dec. 28, 1967
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Duff — LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel, Coeurd'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

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2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED JAN 8 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5545
Local Reg. No. 262
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 2015 N. 7th Street 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 281 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 2015 N. 7th Street

3. NAME OF DECEASED (Type or Print)
a. (First): Charles
b. (Middle): Stacy
c. (Last): Crawford

4. DATE OF DEATH (Month) (Day) (Year): December 22, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Nov 21, 1890
9. AGE (In years last birthday): 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mechanic 21
10b. KIND OF BUSINESS OR INDUSTRY: Own Shop
11. BIRTHPLACE (State or foreign country): Missouri
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Crawford — BIRTHPLACE: ------
14. MOTHER'S MAIDEN NAME: Luella Wedge — BIRTHPLACE: Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 533-03-7382
17. INFORMANT'S OWN SIGNATURE: X Carrie J Crawford — ADDRESS: Ida. Coeur d'Alene

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

331X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Aug, 1967, *to* Dec 22, 1967, *that I last saw the deceased alive on* Dec 22, 1967, *and that death occurred at* 1 a *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 799 (Degree or title) Md
23b. ADDRESS Coeur d'Alene Id
23c. DATE SIGNED 12/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-27-1967
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: Dec 28, 1967
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Duff
LICENSE NO.: E-439

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Frederickson

Certificate of Death

STATE OF IDAHO

State File No. 5546
Local Reg. No. 261
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JAN 8 1968 Vital Statistics Bureau of Health

1. PLACE OF DEATH
a. COUNTY Kootenai 28
b. CITY OR TOWN Coeur d'Alene 000
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION Pinewood Manor Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonner 09
c. CITY OR TOWN Sandpoint
d. STREET ADDRESS (If rural, give location) 401 Euclid

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Eda	S. 261	Boughton	Dec. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed	March 29, 1878	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Michigan	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Joseph Sayles	New York	Antoinette Moye	Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-30-2619	Donald J. Boughton	Ida Coeur d'Alene

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebro Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 2 days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension — Chronic.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 7/10/67, 19___, *to* 12/23/67, 19___, *that I last saw the deceased alive on* 12/23/67, 19___, *and that death occurred at* 5:10 P *m., from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
Lynn C. Fredrickson MD 177 (Degree or title)	Coeur d'Alene, Idaho	

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-28-1967	Forest Cemetery	Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan. 4, 1968	Lorraine K. Brush	Bill Neff	E-439

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel, Coeur d'Alene

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5547
Local Reg. No. 269
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 1036 Govt Way

3. NAME OF DECEASED (Type or Print): a. (First) Frank; b. (Middle); c. (Last) Taylor

4. DATE OF DEATH: (Month) (Day) (Year): 12-23-67

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 6-23-1884

9. AGE (In years last birthday): 83
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor 06

10b. KIND OF BUSINESS OR INDUSTRY: Trentwood

11. BIRTHPLACE (State or foreign country): Detroit Mich

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Abner Taylor
BIRTHPLACE: Ohio

14. MOTHER'S MAIDEN NAME: Lucy Platt
BIRTHPLACE: Mich

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 536 07 9489

17. INFORMANT'S OWN SIGNATURE: Mrs. Green
ADDRESS: Coeur d'Alene Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Chronic Myocarditis — INTERVAL BETWEEN ONSET AND DEATH: 4 Years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Pulmonary Congestion — 1 week; Pneumonia — 1 week

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* June, 1964, *to* 12/23/67, 19___, *that I last saw the deceased alive on* 12/23/67, 19___, *and that death occurred at* 12:30 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. Stevenson, 225 (Degree or title) M.D.

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 12/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-29-67

24c. NAME OF CEMETERY OR CREMATORY: Restlawn

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: January 2, 1968

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland
LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5548
Local Reg. No.
Reg. Dist. No.

RECEIVED JAN 3 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 280 Kootenia 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Cataldo
c. LENGTH OF STAY (in this place) Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) One Mile West of Cataldo Ida.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 280 Kootenia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Cataldo
d. STREET ADDRESS (If rural, give location) Route 1 Cataldo, Idaho

3. NAME OF DECEASED (Type or Print) a. (First) Virgil b. (Middle) Victor c. (Last) Evans

4. DATE OF DEATH (Month) (Day) (Year) Dec. 24, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married

8. DATE OF BIRTH March 22, 1942

9. AGE (In years last birthday) 25 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician 07

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Branch Missouei

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Virgil Evans BIRTHPLACE Missouei

14. MOTHER'S MAIDEN NAME Edna Stidham BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) 1962-1965

16. SOCIAL SECURITY NO. 519-48-1626

17. INFORMANT'S OWN SIGNATURE Carolyn Evans ADDRESS Cataldo Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Skull — INTERVAL BETWEEN ONSET AND DEATH: about 45 minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Highway

21c. (CITY, TOWN, OR TOWNSHIP) Rural Cataldo (COUNTY) 280 Kootenai (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-24-67 about 9:35 a.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Struck by a car

22. *I hereby certify that I attended the deceased from* 12-24 1967, *to* 12-24, 1967, *that I last saw the deceased alive on* 12-24, 1967, *and that death occurred at* about 10:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) T.M. Peterson, M.D.

23b. ADDRESS Wallace, Idaho

23c. DATE SIGNED 12-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 27, 1967

24c. NAME OF CEMETERY OR CREMATORY Bisaro Family Plot

24d. LOCATION (City, town, or county) Kingston, (State) Idaho

DATE REC'D BY LOCAL REG. 1-2-68

REGISTRAR'S SIGNATURE

25. EMBALMER Ronald Maisel LICENSE NO. E452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 8 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Hughes

RECEIVED JAN 8 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5549
Local Reg. No. 268
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): K. M. Hosp 101

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d'Alene
d. STREET ADDRESS (If rural, give location): 303 Locust

3. NAME OF DECEASED (Type or Print): a. (First) Minnie b. (Middle) H c. (Last) Schmidt

4. DATE OF DEATH: (Month) 12 (Day) 25 (Year) 67

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: 6-29-1897

9. AGE (In years last birthday): 70 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Bisbee Ariz.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unkown BIRTHPLACE: Unkown

14. MOTHER'S MAIDEN NAME: Unkown BIRTHPLACE: Unkown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None (If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518 03 0859

17. INFORMANT'S OWN SIGNATURE: B Mrs. Vivian Butterfield ADDRESS: CdA. Ida

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1533

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma sigmoid with

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) metastases abdominal viscera and lungs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: (a) 6 months

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Exam. Transverse Colostomy

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1950, 19__, *to* 12-25, 1967, *that I last saw the deceased alive on* 12-25, 1967, *and that death occurred at* 4 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: W Hughes MD 251 (Degree or title)

23b. ADDRESS: Coeur d'Alene Idaho

23c. DATE SIGNED: 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-28, 1967

24c. NAME OF CEMETERY OR CREMATORY: Restlawn

24d. LOCATION (City, town, or county) (State): Coeur d'Alene Idaho

DATE REC'D BY LOCAL REG.: January 2, 1968

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Fred Noland LICENSE NO.: E-493

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5550
Local Reg. No. 265
Reg. Dist. No. 120

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 8 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Pinewood Manor 261

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Kootenai 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
d. STREET ADDRESS (If rural, give location) 419 Dollar

3. NAME OF DECEASED (Type or Print)
a. (First) George
b. (Middle) D.
c. (Last) Miles

4. DATE OF DEATH (Month) Dec. (Day) 26 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Aug. 5, 1886
9. AGE (In years last birthday) 81 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer 21
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Big Rapids, Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George D. Miles — BIRTHPLACE Pennsylvania
14. MOTHER'S MAIDEN NAME Caroline Wetzell — BIRTHPLACE Pennsylvania

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW I 3
16. SOCIAL SECURITY NO. 519-10-5926
17. INFORMANT'S OWN SIGNATURE Ed Miles (120) — ADDRESS Coeur d'Alene, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4818

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Influenza

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* Dec 25, 1967, *that I last saw the deceased alive on* 26 Dec, 1967, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 192 (Degree or title) MD
23b. ADDRESS 302 N 5th Cdl
23c. DATE SIGNED 29 Dec

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation 2
24b. DATE 12-31-1967
24c. NAME OF CEMETERY OR CREMATORY Moon Crematory
24d. LOCATION (City, town, or county) Sandpoint (State) Idaho

DATE REC'D BY LOCAL REG. January 27, 1968
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER N. F. Riplinger, Jr.
LICENSE NO. E-397

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: English Chapel, Coeur d'Alene,

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN. 9 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5551
Local Reg. No. 260
Reg. Dist. No. 120

BIRTH NO.

RECEIVED JAN 8 1968 Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Kootenai 281

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene (Rural-Hayden)

c. LENGTH OF STAY (in this place): 30 yrs.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Sunset Tarrace 340

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: Kootenai 281

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene

d. STREET ADDRESS (If rural, give location): 910 3rd. St.

3. NAME OF DECEASED (Type or Print): a. (First) Mina b. (Middle) L. c. (Last) Andrews

4. DATE OF DEATH: (Month) Dec. (Day) 26, (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: 3-5-1876

9. AGE (In years last birthday): 91 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own home

11. BIRTHPLACE (State or foreign country): Minn.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Peter Erickson — BIRTHPLACE: Wisc.

14. MOTHER'S MAIDEN NAME: Tenia Tennis — BIRTHPLACE: Wisc.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT'S OWN SIGNATURE: Doulash Andrews — ADDRESS: Coeur d' Alene, Id.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 493X Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: few min.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) pneumonia — 24 hr.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-12, 1967, *to* 12-26, 1967, *that I last saw the deceased alive on* 12-26, 1967, *and that death occurred at* 5:40 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. Stanley Barclay M.D. 025 (Degree or title)

23b. ADDRESS: Coeur d Alene Ida

23c. DATE SIGNED: 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

24b. DATE: 12-29-1967

24c. NAME OF CEMETERY OR CREMATORY: Hazeen and Jaeger

24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: January 2, 1968

REGISTRAR'S SIGNATURE: Lorraine K. Brush

25. EMBALMER: Gilbert D. Yates

LICENSE NO.: E-365

FIRM NAME: Yates Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5552
Local Reg. No. 266
Reg. Dist. No. 120

RECEIVED JAN 8 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 281
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Coeur d' Alene
d. STREET ADDRESS (If rural, give location): 308 Davidson

3. NAME OF DECEASED (Type or Print)
a. (First): Christopher
b. (Middle): 101
c. (Last): Roholt

4. DATE OF DEATH (Month) (Day) (Year): December 29, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: June 8, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Druggist 21
10b. KIND OF BUSINESS OR INDUSTRY: Drug Store
11. BIRTHPLACE (State or foreign country): Minnesota
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Michael C. Roholt — BIRTHPLACE: Norway
14. MOTHER'S MAIDEN NAME: Ann Halstead — BIRTHPLACE: Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----- (If yes, give war or dates of service) ----------
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE: Nelson Crane — ADDRESS: 6824 West Markham Little Rock Ark. 72205

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4301

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute Myocardial Infarction

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* November, 1966, *to* _____, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 128 (Degree or title)
23b. ADDRESS: Coeur d' Alene, Ida.
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1-3-1968
24c. NAME OF CEMETERY OR CREMATORY: Forest Cemetery
24d. LOCATION (City, town, or county) (State): Coeur d' Alene, Idaho

DATE REC'D BY LOCAL REG.: Jan. 4, 1968
REGISTRAR'S SIGNATURE: Lorraine K. Brush
25. EMBALMER: Bill Duff
LICENSE NO.: E-439

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: English Chapel-Coeur d'Alene

DUTIES:

FEB 6 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Wi Fox

RECEIVED
JAN 15 1968
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5553
Local Reg. No. 273
Reg. Dist. No. 120

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Kootenai 281 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Coeur d'Alene
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Kootenai Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 280 Kootenai
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Post Falls
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print)
a. (First) Clinton
b. (Middle) 101 S.
c. (Last) Eggers

4. DATE OF DEATH (Month) (Day) (Year) December 31, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) 3 Married
8. DATE OF BIRTH March 30, 1890
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tall Sawyer 17
10b. KIND OF BUSINESS OR INDUSTRY Sawmill
11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Eggers — BIRTHPLACE North Carolina
14. MOTHER'S MAIDEN NAME Alice Greer — BIRTHPLACE North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. 518-03-3962
17. INFORMANT'S OWN SIGNATURE Ella Eggers (SD) — ADDRESS Post Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3318

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Arteriosclerosis — 10 yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1955, *to* 12/31, 1967, *that I last saw the deceased alive on* 12/5, 1967, *and that death occurred at* 11:15 P *m., from the causes and on the date stated above.*

23a. SIGNATURE Ernest Fox M.D. 174 (Degree or title)
23b. ADDRESS Coeur d'Alene, Idaho
23c. DATE SIGNED 1-4-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1-4-1968
24c. NAME OF CEMETERY OR CREMATORY Forest Cemetery
24d. LOCATION (City, town, or county) Coeur d'Alene, (State) Idaho

DATE REC'D BY LOCAL REG. Jan 9, 1968
REGISTRAR'S SIGNATURE Lorraine K. Brush
25. EMBALMER Bill Neuff — LICENSE NO. E-439

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME English Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 8 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 11 1972

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 15 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5554
Local Reg. No. 161
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latha 291 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Willis Sweet Hall 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 528 Linden Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Alan
b. (Middle): Lee
c. (Last): Strong

4. DATE OF DEATH (Month) (Day) (Year): December 8, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Student
8. DATE OF BIRTH: May 24, 1949
9. AGE (In years last birthday): 18 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Brush, Coloardo
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Lawrence Strong — BIRTHPLACE: Iowa
14. MOTHER'S MAIDEN NAME: Phyllis Smith — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 540-58-3434
17. INFORMANT'S OWN SIGNATURE: Lawrence E. Strong — ADDRESS: Lewiston

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Gunshot Wound - Self Inflicted — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

9 76X

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Suicide 21
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 13 Moscow Latah 291 Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): December 8, 1967 7:45 A.M.
21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [X]
21f. HOW DID INJURY OCCUR? Self Inflicted

22. *I hereby certify that I attended the deceased from* Dec 8 1967, *19*__, *to* ____, *19*__, *that I last saw the deceased alive on* ____, *19*__, *and that death occurred at* 7:45 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: R. D. Brooks 058 (Degree or title): M.D.
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: Dec. 12, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-13-67
24c. NAME OF CEMETERY OR CREMATORY: Bell-Crest Memorial Park
24d. LOCATION (City, town, or county) (State): Salem, Oregon

DATE REC'D BY LOCAL REG.: 12-14-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Fred J. Nelson — LICENSE NO.: E-504

FIRM NAME: Short's Funeral Chapel, Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

MAR 13 1968

MAR 15 1968

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 26 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5555
Local Reg. No. 162
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): City Parking Lot 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Latah 291
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 618 South Logan

3. NAME OF DECEASED (Type or Print)
a. (First): Lee
b. (Middle): Roy
c. (Last): Flansburg

4. DATE OF DEATH (Month) (Day) (Year): December 13, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: January 31, 1895
9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Rug & Upholstery 06
10b. KIND OF BUSINESS OR INDUSTRY: Cleaning
11. BIRTHPLACE (State or foreign country): Brainard, Minnesota
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Flansburg — BIRTHPLACE
14. MOTHER'S MAIDEN NAME: Laura Bingham — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes — (If yes, give war or dates of service): WW 1 3
16. SOCIAL SECURITY NO.: 518-03-2917
17. INFORMANT'S OWN SIGNATURE: X Chester L Flansburg — ADDRESS: Sunnyvale, Calif.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Acute Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b): Coronary Sclerosis — 25 years
DUE TO (c): General arteriosclerosis — 25 years

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*: Had about 4 gentle cart attack since 1954

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.: —
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: —

22. *I hereby certify that I attended the deceased from* 12-5, 1953, *to* 12-13, 1967, *that I last saw the deceased alive on* 12-5, 1967, *and that death occurred at* 2:15 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Joseph Wilson MD 567 (Degree or title)
23b. ADDRESS: Moscow Idaho
23c. DATE SIGNED: 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-16-67
24c. NAME OF CEMETERY OR CREMATORY: Fairmont Cemetery
24d. LOCATION (City, town, or county) (State): Spokane Washington

DATE REC'D BY LOCAL REG.: 12-21-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Fred J Nelson — LICENSE NO.: E-504
FIRM NAME: Short's Funeral Chapel Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

JAN 10 1968

FEB 6 1968

FEB 12 1968

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5556
Local Reg. No. 1
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 291 — 2-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow — LENGTH OF STAY (In this place): 7 Yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 205 N. Lilly

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Chester	Ray	Hicks	Dec. 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	White	Married	Dec. 31, 31, 1898	68		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Knox County, Missouri
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Charles Hicks	Illonis	Alloa Shahan	Missouri

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO. 518-16-1889A
17. INFORMANT'S OWN SIGNATURE: Mrs Chester Hicks — ADDRESS: Moscow Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chronic bronchitis — Several years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Massive cerebro vascular accident with residual right hemiplegia. — 9 months

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1961, *to* 16 Dec., 1967, *that I last saw the deceased alive on* 5 Dec., 1967, *and that death occurred at* 5:25 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title)	23b. ADDRESS	23c. DATE SIGNED
328 W.P. Marinead, M.D.	129 W. Third, Moscow, Ida.	12/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-20-67	Freeze Cemetery	Potlatch Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-5-68	Cheryl Ann Williams	Fred D. Nelson — Stone & Funeral Chapel, Moscow, Idaho	E-504

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

JAN 9 1968

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 26 1967 Bureau of Vital Statistics

State File No. 5557
Local Reg. No. 163
Reg. Dist. No. 200

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 29 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 11 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 29 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): Rt. 1

3. NAME OF DECEASED (Type or Print)
a. (First): Annie
b. (Middle): May 329
c. (Last): Putman

4. DATE OF DEATH (Month) (Day) (Year): Dec. 17, 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Feb. 25, 1889

9. AGE (In years last birthday): 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Antaum, Pennsylvania

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: William Fowler
BIRTHPLACE: England

14. MOTHER'S MAIDEN NAME: Mary Logan
BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-01-2575B

17. INFORMANT'S OWN SIGNATURE: X Mrs. Grocy Putman
ADDRESS: Moscow, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Cerebral vascular accident
INTERVAL BETWEEN ONSET AND DEATH: Immed. ate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Cerebral vascular accident
DUE TO (c): Lymphosarcoma of urethra

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 1, 1967, *to* Dec. 17, 1967, *that I last saw the deceased alive on* Dec. 12, 1967, *and that death occurred at* 12:55 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Edward L. Boas 788 (Degree or title)

23b. ADDRESS: Professional Bldg. Moscow

23c. DATE SIGNED: 12-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 19, 1967

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Gardens

24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 12-21-67

REGISTRAR'S SIGNATURE: Cheryl Ann Williams

25. EMBALMER: Fred Nelson

LICENSE NO.: E-504

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

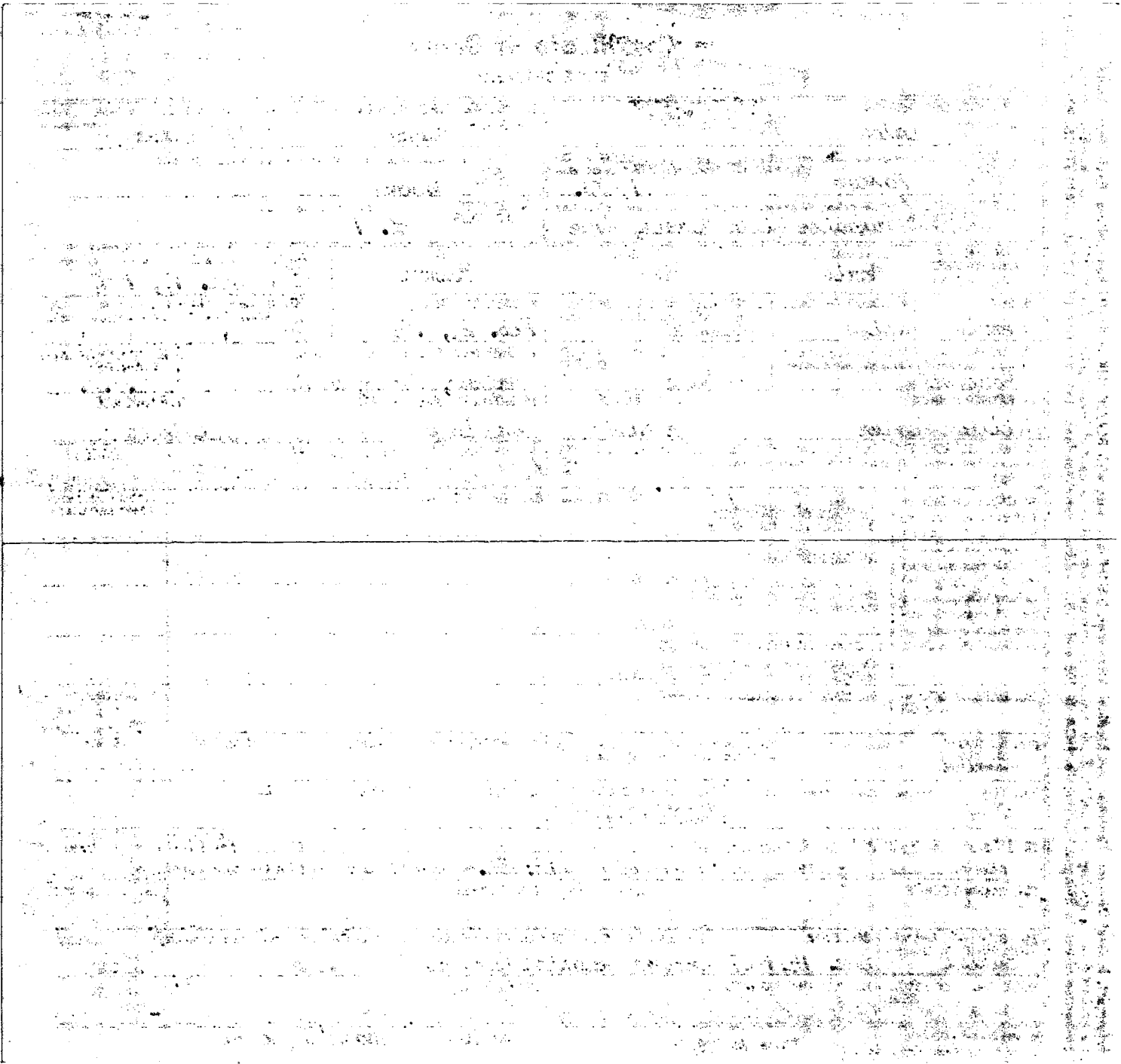

Certificate of Death

STATE OF IDAHO

State File No. 5558
Local Reg. No. 164
Reg. Dist. No. 200

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
LENGTH OF STAY (in this place): 9 Mos
d. FULL NAME OF HOSPITAL OR INSTITUTION: Paradise Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 050 Benewah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): St. Maries
d. STREET ADDRESS (If rural, give location): —

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) C. c. (Last) Bird

4. DATE OF DEATH: (Month) Dec. (Day) 21, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Unknown

8. DATE OF BIRTH: Aug. 7. 1875

9. AGE (In years last birthday): 92
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Woods work

10b. KIND OF BUSINESS OR INDUSTRY: 17 Various

11. BIRTHPLACE (State or foreign country): Minnesota

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Unknown
BIRTHPLACE

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO.: 518-03-3271

17. INFORMANT'S OWN SIGNATURE: Stanley Reese
ADDRESS: St. Maries

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 day

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

493X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1967, *to* Dec. 21, 1967, *that I last saw the deceased alive on* Dec. 12, 1967, *and that death occurred at* 9:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE: Edward L. Boas 788 (Degree or title)

23b. ADDRESS: Professional Bldg. Moscow

23c. DATE SIGNED: 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Buried

24b. DATE: 12-26-67

24c. NAME OF CEMETERY OR CREMATORY: Woodlawn

24d. LOCATION (City, town, or county) (State): St. Maries Idaho

DATE REC'D BY LOCAL REG.: 12-29-67

REGISTRAR'S SIGNATURE: Cheryl Ann Williams

25. EMBALMER: Gerald Broemmer E-411

LICENSE NO.

FIRM NAME: Broemmer Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5559
Local Reg. No. 165
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 2 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Latah 29
b. CITY OR TOWN: Moscow
LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION: VA Gritman Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 290 Latah
c. CITY OR TOWN: Bovill
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Dorothy	Ann	Sanderson	Dec	21	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	married	July 29, 1932	35				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Eatonville, Wash.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Victor Pearson — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Dorothy York — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Bovill

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1714 Carcinoma Cervix uteri — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 1967 *to* Dec 21, 1967 *that I last saw the deceased alive on* 12-21, 1967 *and that death occurred at* 6:8 m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
David C. Valder MD. 541	Moscow Idaho	12-27

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 27, 1967	Moscow Cemetery	Moscow Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-29-67	Cheryl Ann Williams	Donald Ward	E-380

FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

SEP 2 1 1989

State File No. 5560
Local Reg. No. 4
Reg. Dist. No. 200

67-12102

BIRTH NO.

RECEIVED JAN 15 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY: Latah 291 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Gritman Hospital 112

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 415 No. Hayes

3. NAME OF DECEASED (Type or Print)
a. (First): Baby Boy
b. (Middle):
c. (Last): Vail

4. DATE OF DEATH (Month) (Day) (Year): Dec 23 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Dec 23, 1967
9. AGE (In years last birthday): 0 — IF UNDER 1 YEAR: Months 0, Days 0 — IF UNDER 24 HRS.: Hours 1, Min. 25

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none 02
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Richard Vail — BIRTHPLACE: Idaho
14. MOTHER'S MAIDEN NAME: Phylis Huff — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: None
17. INFORMANT'S OWN SIGNATURE: X Richard E. Vail — ADDRESS: Moscow, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

776X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PREMATURITY — INTERVAL BETWEEN ONSET AND DEATH: 1 HR

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at 3:00 m., from the causes and on the date stated above.*

23a. SIGNATURE 328 (Degree or title): [signature]
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 2 Jan 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
24b. DATE: Dec 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Gritman Hospital
24d. LOCATION (City, town, or county) (State): Moscow Idaho

DATE REC'D BY LOCAL REG.: 12-68
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Donald Ward
LICENSE NO.: E-380

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME: Short's Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

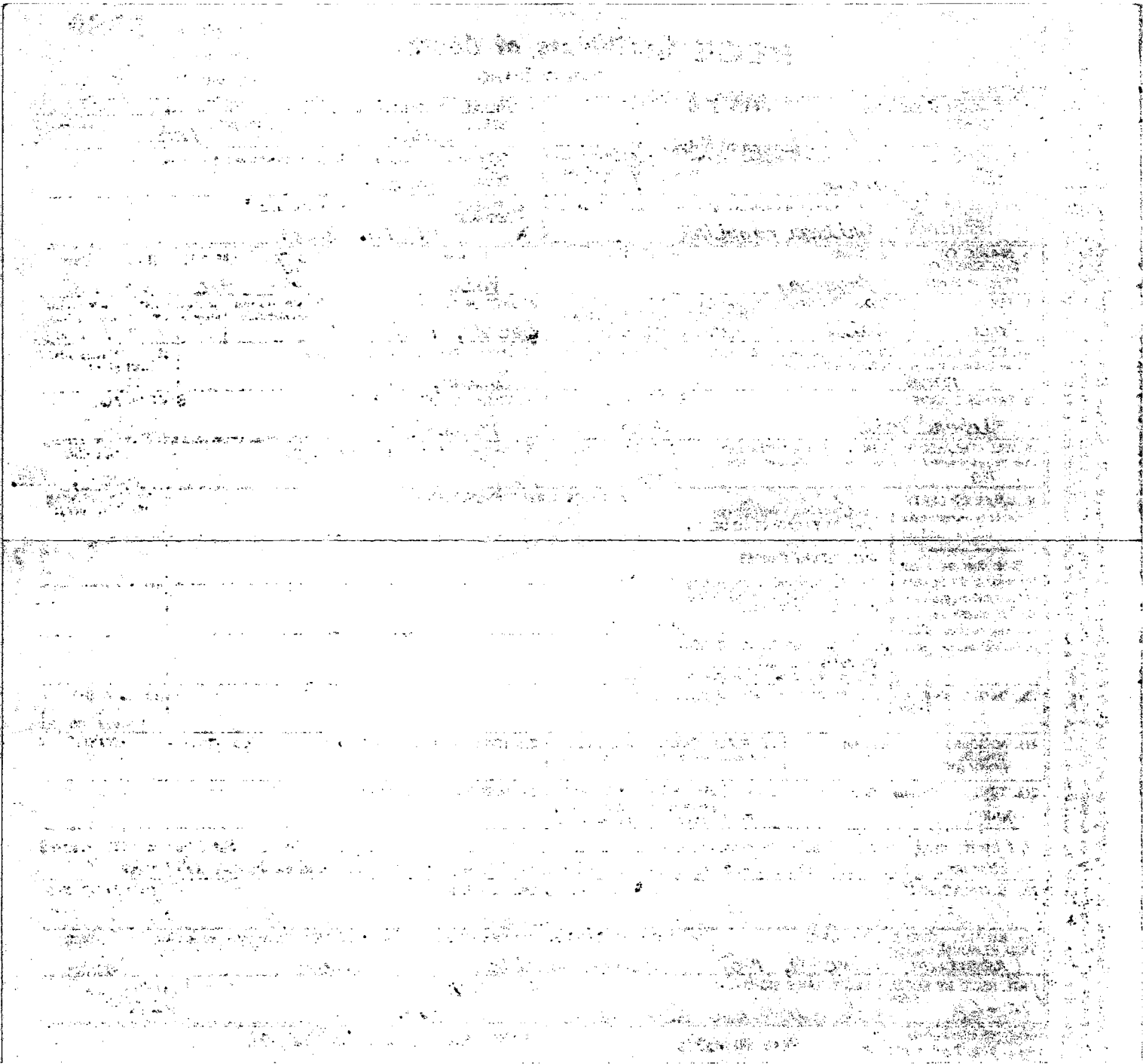

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5561
Local Reg. No. 166
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JAN 2 1968 Bureau of Vital Statistics

291 2-01

1. PLACE OF DEATH
a. COUNTY: Latah
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 12 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Paradise Villa Nursing Home

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 290 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Kendrick
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Adrienne
b. (Middle): 339 Alexina
c. (Last): Clemenhagen

4. DATE OF DEATH: Dec 23 1967 (Month) (Day) (Year)

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 2 widowed

8. DATE OF BIRTH: May 12, 1877

9. AGE (In years last birthday): 90
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Magny, France

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Moser
BIRTHPLACE: Switzerland

14. MOTHER'S MAIDEN NAME: Unknown
BIRTHPLACE: France

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 531-52-9502

17. INFORMANT'S OWN SIGNATURE: X Robt H. Clemenhagen
ADDRESS: Kendrick, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

794X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Complications of Age
INTERVAL BETWEEN ONSET AND DEATH: Recent

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 12-5, 1967, *to* 12-23, 1967, *that I last saw the deceased alive on* 12-15, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: Omer H Dimpy 148
(Degree or title): MD
23b. ADDRESS: Troy Idaho
23c. DATE SIGNED: 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 28, 1967
24c. NAME OF CEMETERY OR CREMATORY: Wild Rose Cemetery
24d. LOCATION (City, town, or county) (State): near Kendrick Idaho

DATE REC'D BY LOCAL REG.: 12-29-67
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Ronald Ward
LICENSE NO.: E-380
FIRM NAME: Short's Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

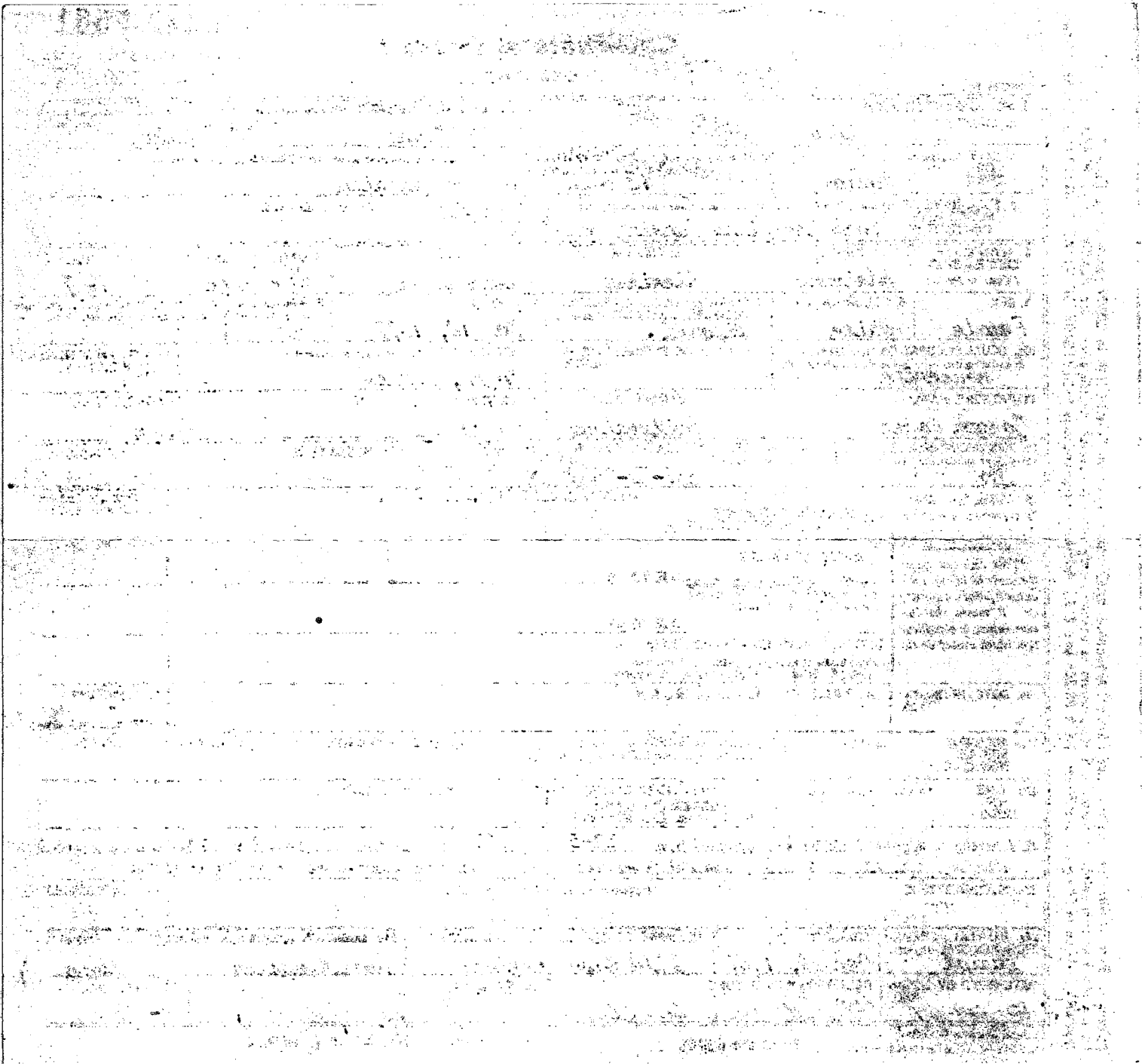

State File No. 5562
Local Reg. No. 3
Reg. Dist. No. 200

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 8 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
c. LENGTH OF STAY (in this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Latah County Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Moscow
d. STREET ADDRESS (If rural, give location): 738 Lynn Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): Fern
b. (Middle): Helen
c. (Last): Nelson

4. DATE OF DEATH (Month) (Day) (Year): December 26, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: September 6, 1911
9. AGE (In years last birthday): 56 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Teacher 12
10b. KIND OF BUSINESS OR INDUSTRY: Education
11. BIRTHPLACE (State or foreign country): Moscow, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: J. M. Scott — BIRTHPLACE: Unknown
14. MOTHER'S MAIDEN NAME: Meta Dewey — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 519-09-5446
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

343X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): encephalitis — INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Dec, 1967, *that I last saw the deceased alive on* 25 Dec, 1967, *and that death occurred at* 2:30P *m., from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 057 (Degree or title)
23b. ADDRESS: Moscow, Idaho
23c. DATE SIGNED: 1/2/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 29, 1967
24c. NAME OF CEMETERY OR CREMATORY: Moscow Cemetery
24d. LOCATION (City, town, or county) (State): Moscow Latah Idaho

DATE REC'D BY LOCAL REG.: 1-5-68
REGISTRAR'S SIGNATURE: Cheryl Ann Williams
25. EMBALMER: Fred J. Nelson
LICENSE NO.: E-504
FIRM NAME: Short's Funeral Chapel Moscow, Idaho

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

JAN 11 1968

Certificate of Death

STATE OF IDAHO

State File No. 5563
Local Reg. No. 2
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 8 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Latah 291
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
LENGTH OF STAY (in this place) 38 Years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Latah County Nursing Home 306

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 291 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Minnie b. (Middle) c. (Last) Arnold

4. DATE OF DEATH (Month) (Day) (Year) December 26, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed

8. DATE OF BIRTH May 24, 1871

9. AGE (In years last birthday) 96
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Homemaker

11. BIRTHPLACE (State or foreign country) Arcadia Wisconsin

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Unknown
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Unknown
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-60-9828

17. INFORMANT'S OWN SIGNATURE x Ethel Arnold
ADDRESS Moscow, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Influenza — Sudden
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9-21-1933, to 12-26-1967, that I last saw the deceased alive on Dec 17, 1967, and that death occurred at 6:00 p.m., from the causes and on the date stated above.

23a. SIGNATURE Joseph T. Wilson M.D. 567 (Degree or title)

23b. ADDRESS Moscow Idaho

23c. DATE SIGNED 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 30, 1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Gardens

24d. LOCATION (City, town, or county) (State) Moscow Latah Idaho

DATE REC'D BY LOCAL REG. 1-5-68

REGISTRAR'S SIGNATURE Cheryl Ann Williams

25. EMBALMER Donald Ward

LICENSE NO. E-380

FIRM NAME: Short & Chapin Moscow, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

JAN 2 0 1972

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5564
Local Reg. No. 5
Reg. Dist. No. 200

BIRTH NO.

RECEIVED JAN 15 1968 Bureau of Vital Statistics

1-08

1. PLACE OF DEATH
a. COUNTY Latah 290
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Deary
LENGTH OF STAY (in this place) 8 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Gritman Memorial Hospital Deary

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 290 Latah
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Moscow Deary
d. STREET ADDRESS (If rural, give location) Deary

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Henry		Hansen	Dec. 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed	July 31, 1890	77				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Woodsman 17	Logger	St. Paul Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Eric N. Hansen	Unknown	Minnie Hansen	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
Yes WWI	534-12-7434	X [illegible] Hansen	Deary, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 9760 Severe Generalized Arteriosclerotic Body. Suffocation. — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Acute Alcoholism — Yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January 1, 1968 *to* Dec. 30, 1967, *that I last saw the deceased alive on* Saturday *19*67, *and that death occurred on the date stated above.* Death probably somewhere in the Deary area.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W. E. Brooks 0583	M.D. Co. Coroner	Moscow Idaho	Jan. 8 1968

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	1-6-68	Pine Crest Cemetery	Deary Latah	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-12-68	Cheryl Ann Williams	Donald Ward Shortis Funeral Chapel Moscow, Idaho	E-380

Federal Security Agency
United States Public Health Service

Form DH-69021

FIRM NAME:

FEB 12 1968

RECEIVED JAN 15 1968

Certificate of Death

STATE OF UTAH

1. PLACE OF DEATH
a. COUNTY Utah
b. CITY OR TOWN Provo
c. FULL NAME OF HOSPITAL OR INSTITUTION Provo Regional Hospital

2. USUAL RESIDENCE
a. COUNTY Utah
b. CITY OR TOWN Provo
c. STREET OR RURAL ROUTE

3. NAME OF DECEASED (Type or Print)

4. SEX Male
5. COLOR OR RACE White
6. MARITAL STATUS Married
7. DATE OF BIRTH (Month, Day, Year)
8. AGE (Last Birthday) 71 Years
9. CITIZEN OF WHAT COUNTRY U.S.A.
10. USUAL OCCUPATION Woodworker
11. FATHER'S NAME Eric N. Hansen
12. BIRTHPLACE Unknown
13. WAS DECEASED EVER IN U.S. ARMED FORCES? No
14. ADDRESS Provo
15. CAUSE OF DEATH
16. INTERVAL BETWEEN ONSET AND DEATH

17. ANTECEDENT CAUSES
Abnormal conditions, if any, giving rise to the above cause, stating the underlying cause last.
18. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to death but not related to the disease or condition causing death.

19. DATE OF OPERATION
20. AUTOPSY
21. DECEDENT'S SOCIAL SECURITY NUMBER
22. TIME OF DEATH
23. DATE OF INJURY
24. PLACE OF INJURY
25. DATE RECEIVED
26. REGISTRAR'S SIGNATURE
27. DATE FILED
28. DATE OF BURIAL
29. CEMETERY OR CREMATORY
30. FUNERAL DIRECTOR
31. DATE SIGNED
32. DATE REGISTERED BY LOCAL REGISTRAR

Form DH-65021

State File No. 5565
Local Reg. No.
Reg. Dist. No.

REC

Certificate of Death

STATE OF IDAHO

BIRTH NO.

DEC 26 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lemhi 300 1-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
c. LENGTH OF STAY (in this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Steele Memorial Hosp. 117

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 300 Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Salmon
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Edna
b. (Middle): Irene
c. (Last): Gutzman

4. DATE OF DEATH (Month) (Day) (Year): Dec. 11, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: Apr. 18, 1899
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): home 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Salmon, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Columbus Bates — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Clara Ann Holbrook — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT'S OWN SIGNATURE: Wanda R. Fern — ADDRESS: Salmon, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio Sclerosis Generalized — INTERVAL BETWEEN ONSET AND DEATH: 2 yr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) with uremia + — 2 days
DUE TO (c) Polycythemia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Gall stones

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1949, 19__, *to* 12-11, 1967, *that I last saw the deceased alive on* 12-11, 1967, *and that death occurred at* 9P *m., from the causes and on the date stated above.*

23a. SIGNATURE: W. N. Harhadar, MD 045 (Degree or title)
23b. ADDRESS: Salmon, Ida
23c. DATE SIGNED: 12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-15-67
24c. NAME OF CEMETERY OR CREMATORY: Salmon
24d. LOCATION (City, town, or county) (State): Salmon, Idaho

DATE REC'D BY LOCAL REG.: Dec 19-67
REGISTRAR'S SIGNATURE: Viola E. Johnson
25. EMBALMER: Delbert C. Jones
LICENSE NO.: E 369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 12 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5566
Local Reg. No. 690
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED
DEC 29 1967
Bureau of Vital Statistics

1. PLACE OF DEATH 300
a. COUNTY Lemhi 1-02
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cobalt
c. LENGTH OF STAY (in this place) 1½ yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 300 Lemhi
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cobalt
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Evelyn b. (Middle) Annie c. (Last) Lonergan Dunn

4. DATE OF DEATH (Month) (Day) (Year) Dec. 16, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Jan. 24, 1908
9. AGE (In years last birthday) 59 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Ouray, Colorado
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William A. Stark BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Lillie Hohngrain BIRTHPLACE Americus, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 524-28-4035
17. INFORMANT'S OWN SIGNATURE Burtford S. Dunn ADDRESS Cobalt

18. CAUSE OF DEATH 975X
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Asphyxiation by drowning — INTERVAL BETWEEN ONSET AND DEATH 0

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Panther Creek & Deep Creek 18 13
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 300 (STATE) Cobalt, Lemhi County, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec. 16, 1967 2 P m. 2
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Jumped off bridge (Intersection of Panther and Deep Creek

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at 2 P m., from the causes and on the date stated above.*

23a. SIGNATURE 583 Delbert Jones Lemhi Co. Coroner (Degree or title) 4
23b. ADDRESS Salmon, Ida
23c. DATE SIGNED 12-19-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12-20-67
24c. NAME OF CEMETERY OR CREMATORY Salmon
24d. LOCATION (City, town, or county) (State) Salmon, Idaho

DATE REC'D BY LOCAL REG. Dec. 26th 67
REGISTRAR'S SIGNATURE Viola E. Johnson
25. EMBALMER Delbert C. Jones
LICENSE NO. E 369

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5567
Local Reg. No. 2
Reg. Dist. No. 237

BIRTH NO.

RECEIVED
DEC 26 1967
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Lewis 310 1-00
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Winchester
c. LENGTH OF STAY (in this place): life
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): own home 006

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 310 Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Winchester
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Everett b. (Middle) Leroy Jones c. (Last) Harris

4. DATE OF DEATH: (Month) Dec. (Day) 16 (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Dec. 12, 1903

9. AGE (In years last birthday): 64 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Millworker 06

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Culdesac, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George Jones — BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Elizabeth Cooper — BIRTHPLACE: Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 16 8044

17. INFORMANT'S OWN SIGNATURE: (Mrs Earl Schneider) — ADDRESS: Lewiston, Id.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart attack — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE 583 (Degree or title): Philip C Davis Coroner, Lewis County

23b. ADDRESS: Craigmont, Idaho

23c. DATE SIGNED: 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Rem-Burial 3

24b. DATE: 12-20-67

24c. NAME OF CEMETERY OR CREMATORY: I.O.O.F. Cemetery

24d. LOCATION (City, town, or county) (State): Craigmont Idaho

DATE REC'D BY LOCAL REG.: 12-18-67

REGISTRAR'S SIGNATURE: [signature]

25. EMBALMER: Robert Larrabee — LICENSE NO.: QL802

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5568
Local Reg. No. 658
Reg. Dist. No. 430

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECE

DEC 22 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Lincoln 320 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hiway 93A Rural
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 7 miles northeast of Richfield 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 070 Blaine
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Hailey,
d. STREET ADDRESS (If rural, give location): 211 N. Main St.

3. NAME OF DECEASED (Type or Print)
a. (First): Emma
b. (Middle): B.
c. (Last): Astuy

4. DATE OF DEATH (Month) (Day) (Year): Dec. 10, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Dec. 19, 1890
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Houdewife 01
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): Chestnut Mound, Tenn.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Ira B. Cowen — BIRTHPLACE: UnKnown
14. MOTHER'S MAIDEN NAME: Marguerite Dobbens — BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518 30 3071
17. INFORMANT'S OWN SIGNATURE: Iris D. Kroul — ADDRESS: Great Falls, Mont.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8164

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Crushed chest — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Auto accident
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 6 Mi East of Richfield, US 20-26 06
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 320 (STATE): Lincoln Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec 10 1967 10:15 A m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Head on collision, chest crushed against Dash

22. *I hereby certify that I attended the deceased from* Did not see alive *, 19___, to _____, 19___, that I last saw the deceased alive on _____, 19___, and that death occurred at* 10:15 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature], Coroner 583
23b. ADDRESS: Shoshone Idaho
23c. DATE SIGNED: 12 15 67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY: Hailey, Cemetery
24d. LOCATION (City, town, or county) (State): Hailey, Idaho

DATE REC'D BY LOCAL REG.: 12-18-67
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Ruth Bird
LICENSE NO.: E. 373

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Bird Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 23 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5569
Local Reg. No. 657
Reg. Dist. No. 430

RECEIVED DEC 15 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lincoln 320 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau of Vital Statistics district): Shoshone
c. LENGTH OF [illegible]
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Woodriver Convalescent Home 240

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 320 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Dietrich
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) William b. (Middle) Edward (Ned) c. (Last) Bolton

4. DATE OF DEATH: (Month) Dec. (Day) 10, (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: June 3, 1895

9. AGE (In years last birthday): 72 | IF UNDER 1 YEAR Months: 6 Days: 7 | IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired garage operator

10b. KIND OF BUSINESS OR INDUSTRY: 20

11. BIRTHPLACE (State or foreign country): Burleigh Falls, Ontario, Can.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Edward Bolton BIRTHPLACE: Ontario, Canada

14. MOTHER'S MAIDEN NAME: Susan Matilda Stone BIRTHPLACE: Ontario, Canada

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I 3

16. SOCIAL SECURITY NO.: 518-36-9131

17. INFORMANT'S OWN SIGNATURE: + Leafy May Bolton ADDRESS: Dietrich, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arteriosclerotic Heart Disease with Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 3yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema — 5yrs

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from January, 1943, to December 10, 1967, that I last saw the deceased alive on December 10, 1967, and that death occurred at 4:15 m., from the causes and on the date stated above.

23a. SIGNATURE: [signature] MD (Degree or title)
23b. ADDRESS: 1968 Shoshone Idaho
23c. DATE SIGNED: 12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-14-1967
24c. NAME OF CEMETERY OR CREMATORY: Shoshone Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 12-13-67
REGISTRAR'S SIGNATURE: Frances M. Bergin
25. EMBALMER: Frances M. Bergin
LICENSE NO.: E-463
FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 25 1974

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5570
Local Reg. No. 659
Reg. Dist. No. 430

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 22 1967 320

1. PLACE OF DEATH
a. COUNTY: Lincoln 320 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone Bureau of Vital Statistics
c. LENGTH OF STAY (in this place): ---
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Outside Shoshone Depot 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 320 Lincoln
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Shoshone
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) DALE b. (Middle) SIMONS c. (Last) BAILEY

4. DATE OF DEATH: (Month) Dec. (Day) 15, (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Oct. 1, 1922
9. AGE (In years last birthday): 45 — IF UNDER 1 YEAR Months: 2 Days: 14 — IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Depot Agent 09
10b. KIND OF BUSINESS OR INDUSTRY: U.P.R.R.
11. BIRTHPLACE (State or foreign country): Burley, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Arthur Claude Bailey-Galena BIRTHPLACE Neb.
14. MOTHER'S MAIDEN NAME: Ruby Simons BIRTHPLACE Payson, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II 4
16. SOCIAL SECURITY NO.: 519-12-2639
17. INFORMANT'S OWN SIGNATURE: Mrs. Dale S. Bailey ADDRESS: Shoshone

4281

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic heart disease — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* January, 1952, *to* Dec, 1967, *that I last saw the deceased alive on* Dec 12, 1967, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title) 386
23b. ADDRESS: Shoshone Idaho
23c. DATE SIGNED: 12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-19-1967
24c. NAME OF CEMETERY OR CREMATORY: Shoshone, Cemetery
24d. LOCATION (City, town, or county) (State): Shoshone, Idaho

DATE REC'D BY LOCAL REG.: 12-20-67
REGISTRAR'S SIGNATURE: Francis M. Bergin
25. EMBALMER: Francis M. Bergin
LICENSE NO.: E-463

FIRM NAME: Bergin Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 22 1967

MAR 15 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED STATE OF IDAHO

DEC 27 1967

Bureau of Vital Statistics

State File No. 5571
Local Reg. No. 56
Reg. Dist. No. 630

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sugar City
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 331 Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Sugar City
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) Samuel b. (Middle) Washington c. (Last) Orme

4. DATE OF DEATH (Month) (Day) (Year): December 8, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: November 2, 1897

9. AGE (In years last birthday): 70 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Tooele, Utah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John Kirby Orme — BIRTHPLACE: Tooele, Utah

14. MOTHER'S MAIDEN NAME: Janet Alexandria Park — BIRTHPLACE: West Weber, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 518-42-9533

17. INFORMANT'S OWN SIGNATURE: John K Orme — ADDRESS: Sugar City, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Sudden

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary heart disease, chronic
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Emphysema, pulmonary Bronchitis, chronic

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 1967, *to* Dec. 8, 1967, *that I last saw the deceased alive on* Dec. 8, 1967, *and that death occurred at* 8 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] 298 (Degree or title)

23b. ADDRESS: Sutton Idaho

23c. DATE SIGNED: 12-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 12, 1967

24c. NAME OF CEMETERY OR CREMATORY: Sugar City Cemetery

24d. LOCATION (City, town, or county) (State): Sugar City, Madison, Idaho

DATE REC'D BY LOCAL REG.: 12-12-67

REGISTRAR'S SIGNATURE: Leona Flamm

25. EMBALMER: James R Flamm — LICENSE NO.: E-477

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5572
Local Reg. No. 56
Reg. Dist. No. 630

Certificate of Death

RECEIVED
JAN 17 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rexburg Rest Home 307

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 331 Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): JOSEPH
b. (Middle): ALFRED
c. (Last): SORENSEN

4. DATE OF DEATH (Month) (Day) (Year): December 28, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4
8. DATE OF BIRTH: April 27, 1874
9. AGE (In years last birthday): 93 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Huntsville, Utah
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Christian S. Sorensen — BIRTHPLACE: Aarahus, Denmark
14. MOTHER'S MAIDEN NAME: Nielsine Andersen — BIRTHPLACE: Aarahus, Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 519-24-0523
17. INFORMANT'S OWN SIGNATURE: Ka Von Sorensen — ADDRESS: Rexburg, Idaho

9037

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: immediately

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Fell in bath tub — Dec 6 1967
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct., 1947, *to* Dec. 28, 1967, *that I last saw the deceased alive on* Dec. 28, 1967, *and that death occurred at* 8:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): M. F. Rigby M.D. 441
23b. ADDRESS: Rexburg Idaho
23c. DATE SIGNED: Dec. 29 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/2/68
24c. NAME OF CEMETERY OR CREMATORY: Sugar City
24d. LOCATION (City, town, or county) (State): Sugar City Madison Idaho

DATE REC'D BY LOCAL REG.: 1-2-68
REGISTRAR'S SIGNATURE: Leona Flamm
25. EMBALMER: Kenneth Flamm — LICENSE NO.: E347

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Flamm Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death or request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5573
Local Reg. No. 57
Reg. Dist. No. 630

RECEIVED JAN 17 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Madison 331
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 331 Madison
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
d. STREET ADDRESS (If rural, give location): 205 E. Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Arthur		Porter	Dec. 30, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Male	Cauc.	Married	April 20, 1876	91		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Businessman 21	Newspaper	Auckland, New Zealand	U.S.A

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Arthur Porter	Leighs, Priory, Essex England	Louise Marie Koebbel	Richmond, Melbourne, Victoria, Australia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		518-18-1764	John C. Porter	Rexburg, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

33/X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: 3 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cerebral arteriosclerosis — several yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan, 1964, *to* 12-30, 1967, *that I last saw the deceased alive on* 12-30, 1967, *and that death occurred at* 10 3/4 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Leslie J. Ellsworth 413	MD	Rexburg Idaho	1-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1/3/68	Rexburg Cemetery	Rexburg, Madison, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-2-68	Lenora Flamm	Russell Flamm	E-254

FIRM NAME: Flamm Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUN 5 1970

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5574
Local Reg. No. 58
Reg. Dist. No. 630

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Madison 331 — JAN 17 1968 — Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg — LENGTH OF STAY (in this place): 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Madison Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: Jefferson 260
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural, Terreton
d. STREET ADDRESS (If rural, give location): Highway #28

3. NAME OF DECEASED (Type or Print): a. (First) RAYMOND — b. (Middle) EARNEST 123 — c. (Last) OSBORNE

4. DATE OF DEATH: (Month) December (Day) 31 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: September 11, 1897

9. AGE (In years last birthday): 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY: Self employed

11. BIRTHPLACE (State or foreign country): Council Grove, Kansas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Allen C. Osborne — BIRTHPLACE: Virginia

14. MOTHER'S MAIDEN NAME: Mary Ellen Drake — BIRTHPLACE: Morris County, Kan.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mary E. Osborne — ADDRESS: Boulder City, Nevada

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 527 Emphysema. — INTERVAL BETWEEN ONSET AND DEATH: 5 years

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*: Congestive heart failure — 1 year

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Aug, 1967, *to* Dec 31, 1967, *that I last saw the deceased alive on* Dec 31, 1967, *and that death occurred at* 11:35 P m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Blaine Hansen 409 M. D.

23b. ADDRESS: 90 South First West, Rexburg, Idaho

23c. DATE SIGNED: 1-6-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Jan. 1, 1968

24c. NAME OF CEMETERY OR CREMATORY: Fielding Memorial Park

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: 1-8-68

REGISTRAR'S SIGNATURE: Leona Hamm

25. EMBALMER: Orland C. Buck

LICENSE NO.: E-250

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 18 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5575
Local Reg. No. 87
Reg. Dist. No. 450

RECEIVED DEC 7 1967 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Minidoka 340 2-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
LENGTH OF STAY (in this place): 5½ months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kathryn's Rest Home 319

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
d. STREET ADDRESS (If rural, give location): 914 "B" Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Mabel	Davis	SMITH	December 3, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Caucasian	Widowed 2	May 28, 1878	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	David City, Nebraska	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Christopher C. Davis	Nebraska	Jennie Roberts	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-62-0977	Charles L Green	Rupert, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Hemorrhage 331X	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)		
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* July, 1967, *to* 12-3, 1967, *that I last saw the deceased alive on* 12-3, 1967 *and that death occurred at* 7:[illegible] *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
I. H. Hunt 255	M.D.	Rupert, Idaho	12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 6, 1967	Rupert Cemetery	Rupert, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
DEC 5-67	Mary Ellen Gashwiler	Charles L Parsons	E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5576
Local Reg. No. 88
Reg. Dist. No. 450

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Minidoka 340 — DEC 19 1967 — 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (In this place) Unknown
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

Bureau of Vital Statistics

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 340 Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) Rural Route 3

3. NAME OF DECEASED (Type or Print): a. (First) Albert — b. (Middle) W. 125 — c. (Last) Glorfield

4. DATE OF DEATH (Month) (Day) (Year): Dec 6 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: Jan 17 1895

9. AGE (In years last birthday): 72 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hartly Iowa

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: William Fredrick Glorfield-Iowa

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Christina Petersen-Boeklund Prussia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) W.W.I 3

16. SOCIAL SECURITY: 700 07 3502

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Mrs Mamie Glorfield

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5020

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: few days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Chronic Bronchitis & Emphasema — several years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Generalized senile changes

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Augu, 1967, *to* Dec 6, 1967, *that I last saw the deceased alive on* Dec 6, 1967, *and that death occurred at* 1:30 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): C J Dalley M D 127

23b. ADDRESS: 702 G St Rupert Idaho

23c. DATE SIGNED: 12/11/67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec 9 1967

24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery

24d. LOCATION (City, town, or county) (State): Rupert Idaho

DATE REC'D BY LOCAL REG.: 12-16-67

REGISTRAR'S SIGNATURE: Mary Ellen Graham

25. EMBALMER: Charles L Peroms — LICENSE NO.: E-494

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 19 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 17 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5577
Local Reg. No. 89
Reg. Dist. No. 450

RECEIVED
DEC 19 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340 3-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 5 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
d. STREET ADDRESS (If rural, give location) Route 1-350 west 400 south

3. NAME OF DECEASED (Type or Print)
a. (First) James
b. (Middle) Albert 125
c. (Last) Handy

4. DATE OF DEATH (Month) Dec (Day) 7 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Mar 22 1875
9. AGE (In years last birthday) 92 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer-Retired 04
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Portsmouth Iowa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Handy — BIRTHPLACE Stratford on Avon England
14. MOTHER'S MAIDEN NAME Martha Causlin — BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) none
16. SOCIAL SECURITY NO. 519-05-2005
17. INFORMANT'S OWN SIGNATURE Leo J. Handy — ADDRESS Heyburn Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

464X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH 15 min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Phlebothrombosis
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept., 1966, *to* Dec 7, 1967, *that I last saw the deceased alive on* Dec. 6, 1967, *and that death occurred at* 6:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE 740 (Degree or title) H. W. Crawford, M.D.
23b. ADDRESS Rupert, Idaho
23c. DATE SIGNED 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 9 1967
24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery
24d. LOCATION (City, town, or county) (State) Heyburn Idaho

DATE REC'D BY LOCAL REG. 12-15-67
REGISTRAR'S SIGNATURE Mary Ellen Carlson
25. EMBALMER Charles H. Persons
LICENSE NO. E-494

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5578
Local Reg. No. 90
Reg. Dist. No. 452

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 19 1967 Bureau of Vital Statistics

BIRTH NO. 3-14

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert Idaho
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 401 "A" Street

3. NAME OF DECEASED (Type or Print) a. (First) CHARLES b. (Middle) RAYMOND 125 c. (Last) JOHNSON

4. DATE OF DEATH (Month) Dec (Day) 8 (Year) 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Dec 14 1900

9. AGE (In years last birthday) 66 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired farmer and

10b. KIND OF BUSINESS OR INDUSTRY 04 store operater

11. BIRTHPLACE (State or foreign country) Richmond Utah

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME C.W.Johnson
BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Emma Pearson
BIRTHPLACE Sweden

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-18-2349

17. INFORMANT'S OWN SIGNATURE X Mary Johnson
ADDRESS Rupert Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 260X Diabetes mellitus and Hemorrhagic Pancreatitis — INTERVAL BETWEEN ONSET AND DEATH several years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov., 1967, *to* Dec 8, 1967, *that I last saw the deceased alive on* Dec 7, 1967, *and that death occurred at* 5:30A m., *from the causes and on the date stated above.*

23a. SIGNATURE W. W. Crawford, M.D., 740 (Degree or title)
23b. ADDRESS Rupert Idaho
23c. DATE SIGNED 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 11 1967
24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery
24d. LOCATION (City, town, or county) Paul (State) Idaho

DATE REC'D BY LOCAL REG. 12-15-67
REGISTRAR'S SIGNATURE Mary Ellen Cashon

25. EMBALMER Charles H Persons
LICENSE NO. E-494

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 29 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Ben Humphrey

BIRTH NO. 67-12173

RECEIVED DEC 19 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5579
Local Reg. No. 91
Reg. Dist. No. 450

1. PLACE OF DEATH
a. COUNTY Minidoka 340 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) East 3rd street Rupert Idaho

3. NAME OF DECEASED (Type or Print) a. (First) DOREEN b. (Middle) Gay 125 c. (Last) COLE

4. DATE OF DEATH (Month) (Day) (Year) Dec 9 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Dec 8 1967

9. AGE (In years last birthday) one day IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) child 02

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Rupert Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Don LeRoy Cole BIRTHPLACE Rupert Idaho

14. MOTHER'S MAIDEN NAME Barbara Fleck BIRTHPLACE Rupert Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE * Don L Cole ADDRESS east 3rd St. Rupert Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

7620

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH 24 hours

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec 8, 1967, *to* Dec 9, 1967, *that I last saw the deceased alive on* Dec 9, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE Ben H. Humphrey 253 (Degree or title) MR,

23b. ADDRESS Rupert Idaho

23c. DATE SIGNED 12-10-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 12. 1967

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 12-15-67

REGISTRAR'S SIGNATURE Mary Ellen Barker

25. EMBALMER Charles L Parsons LICENSE NO. E494

FIRM NAME: WALK MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Dr Humphrey

Certificate of Death

STATE OF IDAHO

State File No. 5580
Local Reg. No. 92
Reg. Dist. No. 460

BIRTH NO.

RECEIVED
DEC 19 1967
Bureau of Vital Statistics

1-02

1. PLACE OF DEATH
a. COUNTY: Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 5 mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 340 Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Paul
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): Bertha
b. (Middle): 125
c. (Last): MAIER

4. DATE OF DEATH (Month) (Day) (Year): December 12, 1967

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Oct. 26, 1885

9. AGE (In years last birthday): 82
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Fairhaven, Illinois

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Karl Kraft
BIRTHPLACE: Germany

14. MOTHER'S MAIDEN NAME: Bertha Mattis
BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): - - - -

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Miriam Koester
ADDRESS: Gooding, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive failure — INTERVAL BETWEEN ONSET AND DEATH: days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): A S C V D. — years
DUE TO (c): Age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

422

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 7-7, 1965, *to* 12-12, 1967, *that I last saw the deceased alive on* 12-14, 1967, *and that death occurred at* 9:00 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE: Ben K. Humphrey 253 (Degree or title) M.D.

23b. ADDRESS: 645 5th St. Rupert Ida.

23c. DATE SIGNED: 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3

24b. DATE: Dec. 15, 1967

24c. NAME OF CEMETERY OR CREMATORY: American Falls Cemetery

24d. LOCATION (City, town, or county) (State): American Falls, Idaho

DATE REC'D BY LOCAL REG.: 12-15-67

REGISTRAR'S SIGNATURE: Mary Ellen Barker

25. EMBALMER: Charles L. Parsons

LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5581
Local Reg. No. 1
Reg. Dist. No. 450

BIRTH NO. RECEIVED

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH 340
a. COUNTY Minidoka JAN 9 - 1968 4-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert Bureau of Vital Statistics
c. LENGTH OF STAY (in this place) 1 hr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert (rural)
d. STREET ADDRESS (If rural, give location) 100 East-075 South (Route 1)

3. NAME OF DECEASED (Type or Print)
a. (First) Clarence
b. (Middle) J 125
c. (Last) GIBSON

4. DATE OF DEATH (Month) (Day) (Year) December 12, 1967

5. SEX Male

6. COLOR OR RACE Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH May 20, 1888

9. AGE (In years last birthday) 79
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (retired) 104

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Hemmingford, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Otto Gibson
BIRTHPLACE Denmark

14. MOTHER'S MAIDEN NAME Ida Evensen
BIRTHPLACE Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) — — — —

16. SOCIAL SECURITY NO. 518-40-9547A

17. INFORMANT'S OWN SIGNATURE Ada L. Gibson
ADDRESS Rupert, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-12, 1967, *to* 12-12, 1967, *that I last saw the deceased alive on* 12-12, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE T. A. Hunt 255 (Degree or title) MD

23b. ADDRESS Rupert, Idaho

23c. DATE SIGNED 12-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 16, 1967

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) (State) Rupert, Idaho

DATE REC'D BY LOCAL REG. 1-2-68

REGISTRAR'S SIGNATURE Mary Ellen Barlow

25. EMBALMER Charles L Parsons

LICENSE NO. E-494

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Walk Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5582
Local Reg. No. 95
Reg. Dist. No. 450

BIRTH NO.

RECEIVED
DEC 26 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Minidoka 340 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Heyburn

c. LENGTH OF STAY (in this place): none

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Snake River Near Heyburn

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho

b. COUNTY: 340 Minidoka

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Heyburn

d. STREET ADDRESS (If rural, give location): Linda Drive

3. NAME OF DECEASED (Type or Print)

a. (First): Douglas

b. (Middle): Jan

c. (Last): Barlow

4. DATE OF DEATH: (Month) Dec. (Day) 14, (Year) 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married

8. DATE OF BIRTH: Jan. 4, 1954

9. AGE (In years last birthday): 14 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student 03

10b. KIND OF BUSINESS OR INDUSTRY: ******

11. BIRTHPLACE (State or foreign country): Jerome, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME — BIRTHPLACE: Golden L. Barlow Jr. - Twin Falls, Ida.

14. MOTHER'S MAIDEN NAME — BIRTHPLACE: Velma Terry - Buhl, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

(If yes, give war or dates of service): none

16. SOCIAL SECURITY NO.: none

17. INFORMANT'S OWN SIGNATURE — ADDRESS: Golden Barlow Jr. Heyburn, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9298

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Accidental drowning while ice skating in river — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Snake River 18

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 1 mile east of Heyburn Idaho 13

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): Dec 14 1967 7PM

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? apparently fell thru hole in ice, couldnt get out.

22. *I hereby certify that I attended the deceased from* Did not see *to* alive, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Robert E. Walk 583 Coroner 4

23b. ADDRESS: 710 6th street Rupert Ida

23c. DATE SIGNED: 12-22-1967

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 18, 1967

24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery

24d. LOCATION (City, town, or county) (State): Heyburn, Idaho

DATE REC'D BY LOCAL REG.: 12-22-67

REGISTRAR'S SIGNATURE: Mary Ellen Barlow

25. EMBALMER: Martha Payne

LICENSE NO.: E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 17 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5583
Local Reg. No. 94
Reg. Dist. No. 450

BIRTH NO.

RECEIVED
DEC 26 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Heyburn
c. LENGTH OF STAY (in this place) None
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Snake River Near Heyburn

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 340 Minidoka
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Heyburn
d. STREET ADDRESS (If rural, give location) Linda Drive Idaho

3. NAME OF DECEASED (Type or Print) a. (First) Arlin b. (Middle) Walter c. (Last) Barlow

4. DATE OF DEATH (Month) (Day) (Year) Dec. 14, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH Jan. 2, 1953

9. AGE (In years last birthday) 15 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03

10b. KIND OF BUSINESS OR INDUSTRY *******

11. BIRTHPLACE (State or foreign country) Jerome, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Golden I. Barlow Jr. - BIRTHPLACE Twin Falls, Ida.

14. MOTHER'S MAIDEN NAME Velma Terry - BIRTHPLACE Buhl, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. none

17. INFORMANT'S OWN SIGNATURE Golden Barlow ADDRESS Heyburn, Ida.

2298

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Accidental drowning while ice skating

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Snake River

21c. (CITY, TOWN, OR TOWNSHIP) 1/2 mile east of Heyburn (COUNTY) 340 (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 14 1967 7PM

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Apparently fell thru hole in ice, couldnt get out.

22. *I hereby certify that I attended the deceased from* did not see alive, 19__, to __, 19__, *that I last saw the deceased alive on* __, 19__, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert E. Walk (Degree or title) Coroner 583

23b. ADDRESS 710 6th street Rupert Ida

23c. DATE SIGNED 12-22-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Dec. 18, 1967

24c. NAME OF CEMETERY OR CREMATORY Riverside Cemetery

24d. LOCATION (City, town, or county) (State) Heyburn, Idaho

DATE REC'D BY LOCAL REG. 12-22-67

REGISTRAR'S SIGNATURE Mary Ellen Barker

25. EMBALMER

LICENSE NO. E-389

FIRM NAME: Payne Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 17 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED JAN 2 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5584
Local Reg. No. 96
Reg. Dist. No. 450

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 717 5th street Rupert Ida

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 717 5th street Rupert Idaho

3. NAME OF DECEASED (Type or Print) a. (First) Helen b. (Middle) 000 c. (Last) Wood

4. DATE OF DEATH (Month) (Day) (Year) Dec 14 1967

5. SEX female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH June 2 1898

9. AGE (In years last birthday) 69 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired waitress

10b. KIND OF BUSINESS OR INDUSTRY Cafe 06

11. BIRTHPLACE (State or foreign country) Tennessee

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME unknown Taylor BIRTHPLACE Tennessee

14. MOTHER'S MAIDEN NAME unknown BIRTHPLACE Tennessee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-14-8004

17. INFORMANT'S OWN SIGNATURE & ADDRESS A Madine Elig T. Griggs Santa Paula Calif.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Arrhythmia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Obesity and excessive alcohol
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) at home 01

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 340 (STATE) Rupert Minidoka County Idaho 13

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Dec 14 67 10 pm

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? excessive drinking over a period of years

22. *I hereby certify that I attended the deceased from* did not see *to* alive, 19___, *that I last saw the deceased alive on* ___ 19___, *and that death occurred at* ___ m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert E Walk 583 (Degree or title) Coroner

23b. ADDRESS 710 6th street Rupert Idaho

23c. DATE SIGNED 12 26 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec 18 1967

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 12-26-67

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER Robert E Walk

LICENSE NO. E294

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. [ICA 38-206 and 215.] Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

W Crawford

Certificate of Death

STATE OF IDAHO

State File No. 5585
Local Reg. No. 92
Reg. Dist. No. 450

BIRTH NO.

RECEIVED
340
DEC 19 1967
000
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Minidoka
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kathryn's Rest Home 319

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 29 Nevada
b. COUNTY: 555
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Elko
d. STREET ADDRESS (If rural, give location): 740 Rahas Road

3. NAME OF DECEASED (Type or Print): a. (First) Emmett; b. (Middle) Henry; c. (Last) BREWINGTON

4. DATE OF DEATH (Month) (Day) (Year): December 14, 1967

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: December 16, 1888

9. AGE (In years last birthday): 78 — IF UNDER 1 YEAR: Months 11, Days 28 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Barber (retired)

10b. KIND OF BUSINESS OR INDUSTRY: 21

11. BIRTHPLACE (State or foreign country): Green Chapel, Missouri

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: unknown Brewington — BIRTHPLACE: Missouri

14. MOTHER'S MAIDEN NAME: unknown — BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 519-18-4521

17. INFORMANT'S OWN SIGNATURE: Darrell V Brewington — ADDRESS: Elko, Nev.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Carcinoma of liver — INTERVAL BETWEEN ONSET AND DEATH: 2 yrs.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: Congestive heart failure

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* July, 1967, *to* Dec. 14, 1967, *that I last saw the deceased alive on* Dec. 10, 1967, *and that death occurred at* 7:30 A *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): W. W. Crawford, M.D. 740

23b. ADDRESS: Rupert, Idaho

23c. DATE SIGNED: 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 20, 1967

24c. NAME OF CEMETERY OR CREMATORY: Rupert Cemetery

24d. LOCATION (City, town, or county) (State): Rupert, Idaho

DATE REC'D BY LOCAL REG.: 12-15-67

REGISTRAR'S SIGNATURE: Mary Ellen Barker

25. EMBALMER: Charles L Parsons — LICENSE NO.: E-494

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 19 1967
MAY 5 1986
MAR 17 2014

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5586
Local Reg. No. 3
Reg. Dist. No. 450

BIRTH NO.

RECEIVED JAN 9 - Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340 — CITY 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert — LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hosp 125

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) Rural Route 4

3. NAME OF DECEASED (Type or Print) — a. (First) William — b. (Middle) James — c. (Last) Hastings

4. DATE OF DEATH (Month) (Day) (Year) Dec 25 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH July 6 1887

9. AGE (In years last birthday) 80 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Alma Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME — BIRTHPLACE Solomon Portland Chase Hastings-Kansas

14. MOTHER'S MAIDEN NAME — BIRTHPLACE Minirva Eunice Wiley- Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No

16. SOCIAL SECURITY NO. 512-09-5805A (If yes, give war or dates of service) None

17. INFORMANT'S OWN SIGNATURE — ADDRESS Ralph Hastings Rt 5 Rupert Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: one hour

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A.S.C.V.D. — Years
DUE TO (c) Age and diabetes — years.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 9-18- , 1960, *to* 12-25-67, 19 , *that I last saw the deceased alive on* 12-25-67 19 , *and that death occurred at* 9 30 *p.m., from the causes and on the date stated above.*

23a. SIGNATURE 253 (Degree or title) Ben K. Humphreys MD

23b. ADDRESS 645 5th St Rupert

23c. DATE SIGNED 1-4 68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-29-1967

24c. NAME OF CEMETERY OR CREMATORY Paul Cemetery

24d. LOCATION (City, town, or county) Paul (State) Idaho

DATE REC'D BY LOCAL REG. 1-2-68

REGISTRAR'S SIGNATURE Mary Ellen Barlow

25. EMBALMER Robert C Walk — LICENSE NO. E 297

FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 10 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5587
Local Reg. No. 97
Reg. Dist. No. 450

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JAN 2 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Minidoka 340
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Minidoka Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 404 B Street

3. NAME OF DECEASED (Type or Print)
a. (First) Rosa
b. (Middle) Ellen 135
c. (Last) Nungesser

4. DATE OF DEATH (Month) (Day) (Year) Dec 25 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Jan 15 1886

9. AGE (In years last birthday) 82
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Cabool Missouri

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME "athew Thomas
BIRTHPLACE Illinois

14. MOTHER'S MAIDEN NAME Amanda Johnson
BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service) none

16. SOCIAL SECURITY NO. 518-07-9800

17. INFORMANT'S OWN SIGNATURE B [illegible] Nungesser
ADDRESS

4201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion
INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov, 19 67, *to* Dec 25, 19 67, *that I last saw the deceased alive on* Dec 25, 19 67, *and that death occurred at* 5:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE A F Kelly 127
(Degree or title) M D
23b. ADDRESS 102 N St Rupert Idaho
23c. DATE SIGNED 12/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec 28 1967
24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery
24d. LOCATION (City, town, or county) (State) Rupert Idaho

DATE REC'D BY LOCAL REG. 12-28-67
REGISTRAR'S SIGNATURE Mary Ellen Jackson

25. EMBALMER Robert C Walk
LICENSE NO. E294
FIRM NAME: Walk Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. JAN 12 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5588
Local Reg. No. 3
Reg. Dist. No. 45

RECEIVED JAN 9 - 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Minidoka 340 1-04
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
c. LENGTH OF STAY (in this place) 4 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Quigley Nursing Home 303

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Minidoka 340
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rupert
d. STREET ADDRESS (If rural, give location) 213 Linden Street

3. NAME OF DECEASED (Type or Print) a. (First) William b. (Middle) Horatio c. (Last) Rice

4. DATE OF DEATH (Month) (Day) (Year) Dec 26 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Oct 31 1879

9. AGE (In years last birthday) 88 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Alta Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Miles Rice
BIRTHPLACE Ohio

14. MOTHER'S MAIDEN NAME Sarah Jane Cassidy
BIRTHPLACE Des Moines Iow

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 518-40-9392

17. INFORMANT'S OWN SIGNATURE Grace V. Hylton ADDRESS Boise Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A.S.C.V.D. — years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-5-62, 19__, *to* 12-13, 1967, *that I last saw the deceased alive on* 12-13, 1967, *and that death occurred at* 2145 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Ben K. Humphrey MD 253 (Degree or title)

23b. ADDRESS Rupert Idaho

23c. DATE SIGNED 1-4-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-30-1967

24c. NAME OF CEMETERY OR CREMATORY Rupert Cemetery

24d. LOCATION (City, town, or county) Rupert, Idaho (State)

DATE REC'D BY LOCAL REG. 1-2-68

REGISTRAR'S SIGNATURE Mary Ellen Carlson

25. EMBALMER Robert C Walk LICENSE NO. E 294

FIRM NAME Walk Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5589
Local Reg. No. 2
Reg. Dist. No. 450

RECEIVED JAN 12 1968 Bureau of V

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Minidoka 340 1-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rupert
c. LENGTH OF STAY (in this place): 1 yr.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Kathryn's Rest Home 319

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 45 Utah
b. COUNTY: 555 Cache
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)
a. (First): George
b. (Middle): Andre
c. (Last): VILLET

4. DATE OF DEATH (Month) (Day) (Year): December 29, 1967

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed

8. DATE OF BIRTH: Sept. 15, 1881

9. AGE (In years last birthday): 86
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Asst. Master Mechanic

10b. KIND OF BUSINESS OR INDUSTRY: Amalgamated Sugar Co.

11. BIRTHPLACE (State or foreign country): Logan, Utah

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Andre Villet
BIRTHPLACE: France

14. MOTHER'S MAIDEN NAME: Jane Baugh
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 528-05-6579

17. INFORMANT'S OWN SIGNATURE: Ernest Villet
ADDRESS: 819 F St Rupert

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 7947 General debilities of age
INTERVAL BETWEEN ONSET AND DEATH: not determined

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY Ooccur?:

22. *I hereby certify that I attended the deceased from* Dec 29, 1967, *to* Dec 29, 1967, *that I last saw the deceased alive on* Dead on arrival, 19__, *and that death occurred at* 12:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE: C J Dalley (Degree or title): M D
23b. ADDRESS: 702 G St Rupert Idaho
23c. DATE SIGNED: Jan 3, 68

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal
24b. DATE: Dec. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Logan Cemetery
24d. LOCATION (City, town, or county) (State): Logan, Utah

DATE REC'D BY LOCAL REG.: Jan. 9-1968
REGISTRAR'S SIGNATURE: Mary Ellen Larson
25. EMBALMER: Charles L Parsons
LICENSE NO.: E-494

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Walk Mortuary

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 12 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5590
Local Reg. No. 285
Reg. Dist. No. 220

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 DEC 1 1 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Bureau of Vital Statistics
c. LENGTH OF STAY (In this place): DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3632 - 13th Street

3. NAME OF DECEASED (Type or Print)
a. (First): ETTA
b. (Middle): A.
c. (Last): THOMAS

4. DATE OF DEATH (Month) (Day) (Year): 1 December 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married
8. DATE OF BIRTH: 18 Feb. 1918
9. AGE (In years last birthday): 49 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper 01
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Spokane, Washington
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fred L. Nicewinter — BIRTHPLACE: Ohio
14. MOTHER'S MAIDEN NAME: Minnie Love — BIRTHPLACE: Oregon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 532 28 0726
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Lewiston, Ida

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9733

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Carbon monoxide poisoning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): self induced
DUE TO (c): as per Report by investigating police officers

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION: Nez Perce Co. Idaho
20. AUTOPSY? YES ☐ NO ☒

21a. ~~ACCIDENT~~ SUICIDE HOMICIDE (Specify): 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 13 Home 01
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 351 (STATE): Lewiston Nez Perce Ida Hospital
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m. 0
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?: [illegible]

22. *I hereby certify that I attended the deceased from* Death on arrival at E.P.M. [illegible] *, 19__, and that death occurred at* 9:00 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or Title): [signature] 446 — Galen A. Rogers, M.D. 900 Seventh St.
23b. ADDRESS: [illegible]
23c. DATE SIGNED: 12/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: 4 Dec 1967
24c. NAME OF CEMETERY OR CREMATORY: Riverside Cemetery
24d. LOCATION (City, town, or county) (State): Spokane, Spokane Co., Wash.

DATE REC'D BY LOCAL REG.: 12-4-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: K. H. Malcom — Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-376

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 16 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5591
Local Reg. No. 291
Reg. Dist. No. 220

BIRTH NO.

RECEIVED DEC 22 1967

1. PLACE OF DEATH
a. COUNTY Nez Perce 35 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Bureau
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Usual Residence 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Nez Perce 35
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 609 Bryden Ave.

3. NAME OF DECEASED (Type or Print) a. (First) MARGARET b. (Middle) MARY c. (Last) SNYDER

4. DATE OF DEATH (Month) (Day) (Year) 1 December 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 23 May 1908

9. AGE (In years last birthday) 59 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher 12

10b. KIND OF BUSINESS OR INDUSTRY Education

11. BIRTHPLACE (State or foreign country) Mica, Washington

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Prince A. Hadisty BIRTHPLACE Missouri

14. MOTHER'S MAIDEN NAME Olive Stimmell BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 543 03 9968

17. INFORMANT'S OWN SIGNATURE Hoyt L. Snyder ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Failure

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pneumonia
DUE TO (c) Cancer of breasts & Lung (metastasis)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: Several months

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/18/1967, to Nov 20, 1967, that I last saw the deceased alive on Nov. 20, 1967, and that death occurred at 7:55 AM., from the causes and on the date stated above.

23a. SIGNATURE 507 Glover MD (Degree or title)

23b. ADDRESS Lewiston Idaho

23c. DATE SIGNED 12/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 4 Dec. 1967

24c. NAME OF CEMETERY OR CREMATORY Normal Hill cemetery

24d. LOCATION (City, town, or county) Lewiston, Idaho (State)

DATE REC'D BY LOCAL REG. 12-6-67

REGISTRAR'S SIGNATURE Lynetta Knott

25. EMBALMER K. H. Malcom

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

LICENSE NO. E-376

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 11 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 29 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 28 1980

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the State registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5592
Local Reg. No. 299
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JAN 10 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Nezperce 35 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 35 Nezperce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) Augusta b. (Middle) M. c. (Last) Patton

4. DATE OF DEATH: (Month) Dec (Day) 2 (Year) 67

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Sept 3 1876

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Cleveland, Ohio

12. CITIZEN OF WHAT COUNTRY?: U S

13. FATHER'S NAME: Charlie Hauth
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: Minnie Hauth
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 519 60 5664

17. INFORMANT'S OWN SIGNATURE: Mrs. J. W. Williams
ADDRESS: Lewiston

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Infirmities of age — 24 hrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pt. bedfast

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* 3/7, 1965, *to* Dec 2, 1967, *that I last saw the deceased alive on* Dec 1, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE: R. M. Glover MD (Degree or title): 507
23b. ADDRESS: 939 Bryden Ave
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec 5 67
24c. NAME OF CEMETERY OR CREMATORY: Community
24d. LOCATION (City, town, or county) (State): Cottonwood Idaho

DATE REC'D BY LOCAL REG.: 12-18-67
REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: Clete Uhlorn
LICENSE NO.: E 421

FIRM NAME: Uhlorn Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 22 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED DEC 22 1967

Certificate of Death

STATE OF IDAHO

State File No. 5593
Local Reg. No. 286
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Lewiston Manor 318

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
d. STREET ADDRESS (If rural, give location): 617 Preston

3. NAME OF DECEASED (Type or Print): a. (First) Charles b. (Middle) E. c. (Last) Robel

4. DATE OF DEATH (Month) (Day) (Year): December 4, 1967

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed

8. DATE OF BIRTH: Jan 2, 1882

9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR Months / Days — IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Orchardist 04

10b. KIND OF BUSINESS OR INDUSTRY: self

11. BIRTHPLACE (State or foreign country): Milbank Junction, North Dakota

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Frank Robel — BIRTHPLACE: Poland

14. MOTHER'S MAIDEN NAME: Eva Fahser — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: no record

17. INFORMANT'S OWN SIGNATURE: Vernon H Robel — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

2001

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic lymphosarcoma to

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Left axilla - chest wall - pulmonary

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH: 3 4 mo

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: Cervicle Axil Neck Disease

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 4/11, 1955, *to* 12-4, 19 67, *that I last saw the deceased alive on* 11-30, 1967, *and that death occurred at* 1030 p m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ralph Hoss M D 195

23b. ADDRESS: Lewiston Ida

23c. DATE SIGNED: 12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3

24b. DATE: Dec. 6, 1967

24c. NAME OF CEMETERY OR CREMATORY: University of Utah

24d. LOCATION (City, town, or county) (State): Salt Lake City, Utah

DATE REC'D BY LOCAL REG.: 12-5-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: Body not embalmed V. Vassar

LICENSE NO.: E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

996.11

DEC 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5594
Local Reg. No. 304
Reg. Dist. No. 220

RECEIVED JAN 10 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35 3-06
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 35 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1207 Cedar

3. NAME OF DECEASED (Type or Print): a. (First) EMERY b. (Middle) WASHINGTON c. (Last) DENNEY

4. DATE OF DEATH: (Month) (Day) (Year) 4 December 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced 4

8. DATE OF BIRTH: 2 June 1882

9. AGE (In years last birthday): 85
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter 91

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Lincoln Co., Wash.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William H. Denney
BIRTHPLACE: NewYork

14. MOTHER'S MAIDEN NAME: Mary Jane Kern
BIRTHPLACE: Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No Record

16. SOCIAL SECURITY NO.: 536 16 0621A

17. INFORMANT'S OWN SIGNATURE: Victoria Rose
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia 1648

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cancer (mediastinum + metastasis to Neck) — INTERVAL BETWEEN ONSET AND DEATH: 2 Weeks

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8/15, 1967 *to* Dec 4, 1967, *that I last saw the deceased alive on* Dec 4, 1967, *and that death occurred at* 7:45 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE: Ron Glover MD, 507 (Degree or title)

23b. ADDRESS: Lewiston, Idaho

23c. DATE SIGNED: 8 Dec 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 7 Dec 1967

24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memo. Gardens

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-22-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: L. E. DeBaun

FIRM NAME: Malcom's Brower-Wann Memorial Chapel

LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Stover

Certificate of Death

STATE OF IDAHO

State File No. 5595
Local Reg. No. 292
Reg. Dist. No. 220

BIRTH NO.

RECEIVED DEC 22 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35 — c. LENGTH OF STAY (in this place): 15 months
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho — b. COUNTY: 350 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sweetwater
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Anna	Myrtle	Holliday	12	4	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Female	White	Widowed	April 15, 1876	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Junction City Oregon
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George W. Hill	Michigan	Jannie Davis	Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT'S OWN SIGNATURE: Floyd Offey — ADDRESS: Lewiston Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4344

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Cardiac decompensation — 1 Week
DUE TO (c) Infirmities of Age

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death: Gangrene of feet

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct 1967, to Dec 4, 1967, that I last saw the deceased alive on Nov 30, 1967, and that death occurred at 308 m., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R. D. Stover 507	M.D.	939 Bryden Ave.	12/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	12/7/67	Vineland Cemetery	Clarkston, Wash.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-8-67	Lynette Knott	W. Merchant	FD 5

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: Merchant Funeral Home — Clarkston Wn.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5596
Local Reg. No. 293
Reg. Dist. No. 220

RECEIVED DEC 22 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 15days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1215-N. St

3. NAME OF DECEASED (Type or Print)
a. (First): Bess
b. (Middle): M.
c. (Last): Williams

4. DATE OF DEATH (Month) (Day) (Year): Dec 6 1967

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: Auf. 5,1883
9. AGE (In years last birthday): 84 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired 29
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Pendleton, Ore.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Gordon Ross, BIRTHPLACE: Mo
14. MOTHER'S MAIDEN NAME: Annie Askren BIRTHPLACE: Ind.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-14-6237
17. INFORMANT'S OWN SIGNATURE: X Barbara M. Seeton ADDRESS:

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypertensive Ht disease — INTERVAL BETWEEN ONSET AND DEATH: 10 yrs

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b) Mitral Lesion — 5 yrs
DUE TO (c) Complete Ht Block. — 3 yrs

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Decompensation and Kerry fracture — 3 Months

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1955, 19__, *to* Dec 6, 1967, *that I last saw the deceased alive on* Dec 6, 1967, *and that death occurred at* 48 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Joseph E Baldick MD 022
23b. ADDRESS: 1522 17th St City
23c. DATE SIGNED: 12/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12-9-67
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 12-8-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Andrew F. Vassar
LICENSE NO.: E315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 22 1967

Certificate of Death
STATE OF IDAHO

State File No. 5597
Local Reg. No. 297
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY Nezperce 351 3-01
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 250 Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kamiah
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Walter	Emry	Timbrook	Dec 6 67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	never married	1909	58				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer 04	Cattle Feeding	unknown	

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
unknown		unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518 05 2674	Admittance Record St. Joseph's Hospital	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Probable Gastric Hemorrhage	> 18 hrs
ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b)	Possible Ulcer	?
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec. 6, 1967, *to* Dec. 6, 1967, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
114	347 St Joseph Way	12/13/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec 9 67	Kamiah	Kamiah Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-18-67	Lynette Knott	Cleland Ahlem	E 421

FIRM NAME: Robertson & Hansen Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5598
Local Reg. No. 294
Reg. Dist. No. 220

RECEIVED DEC 22 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 35 1-46
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 46 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 312-17th Avenue 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 312-17th Avenue

3. NAME OF DECEASED (Type or Print): a. (First) Peter; b. (Middle) William; c. (Last) Schnettler

4. DATE OF DEATH: (Month) (Day) (Year) December 6, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 42

8. DATE OF BIRTH: May 31, 1886

9. AGE (In years last birthday): 81 | IF UNDER 1 YEAR: Months, Days | IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker 21

10b. KIND OF BUSINESS OR INDUSTRY: Plumbing

11. BIRTHPLACE (State or foreign country): Lincoln, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: John Schnettler
BIRTHPLACE: no record

14. MOTHER'S MAIDEN NAME: no record
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518-01-2661

17. INFORMANT'S OWN SIGNATURE: [signature]
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4291

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 Hr.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. None

19a. DATE OF OPERATION: None

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): No

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Lewiston

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May 12, 1968 *, to* _____, 19____, *that I last saw the deceased alive on* Nov. 1, 1967, *and that death occurred at* 5 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: W. S. Douglas M.D. (Degree or title)

23b. ADDRESS: 307 St. John's Way, Lewiston,

23c. DATE SIGNED: 12/8/67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 9, 1967

24c. NAME OF CEMETERY OR CREMATORY: Lewis-Clark Memorial Gardens

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-8-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: V. Vassar

LICENSE NO.: E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5599
Local Reg. No. 305
Reg. Dist. No. 220

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce 351 JAN 10 1968 5-05
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Bureau of Vital Statistics
c. LENGTH OF STAY (In this place): monents
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Street - 627/8 Lindsy Creek Rd.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1502 - 18th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): CYRUS
b. (Middle): 000 ELDRED
c. (Last): HENRY, Jr.

4. DATE OF DEATH (Month) (Day) (Year): 9 December 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): 3 Married
8. DATE OF BIRTH: 25 Sept 1935
9. AGE (In years last birthday): 32 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer 06
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Cyrus E. Henry — BIRTHPLACE: Oklahoma
14. MOTHER'S MAIDEN NAME: Ethel Heasley — BIRTHPLACE: Oklahoma

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): Korea 7
16. SOCIAL SECURITY NO.: 519 36 2833
17. INFORMANT'S OWN SIGNATURE: X Rosalee E. Henry — ADDRESS: Lewiston, Idaho

8234

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Shock & Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: monents

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): chest and back injuries
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): public street 04
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) 351 (STATE): 13 rural, Lewiston, NezPerce Co., Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 9 Dec 1967 12:45 AM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Auto, out of control, went thru a wooden fence.

22. *I hereby certify that I attended the deceased from - - - - - -, 19 - - to - - - - - -, 19 - -, that I last saw the deceased alive on - - - - - -, 19 - -, and that death occurred at* 12:45 AM *, from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Duclos 583 (Degree or title): 4 NezPerce Co. Coroner
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 12 Dec '67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial 1
24b. DATE: 13 Dec 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-22-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: K. H. Malcom — Malcom's Brower-Wann Memorial Chapel
LICENSE NO.: E-376

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 1 1 1969

APR 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5600
Local Reg. No. 295
Reg. Dist. No. 220

RECEIVED DEC 22 1967 Bureau of Vital Statistics 3-01

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: NezPerce 351
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 1day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 1824- Main St 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: NezPerce 351
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 3611-15th St

3. NAME OF DECEASED (Type or Print): a. (First) Wilma; b. (Middle) Jean; c. (Last) Hayhurst

4. DATE OF DEATH: (Month) Dec. (Day) 10 (Year) 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: Feb 28, 1943
9. AGE (In years last birthday): 24 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife 01
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Brewer, Arkansas
12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Otis Thompson — BIRTHPLACE: Arkansas
14. MOTHER'S MAIDEN NAME: Mildred Kemp — BIRTHPLACE: Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-46-3316
17. INFORMANT'S OWN SIGNATURE: X Robin Hayhurst — ADDRESS: Lewiston, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Apparent overdose of sleeping pills — INTERVAL BETWEEN ONSET AND DEATH: minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): suicide 2
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): motel room 15
21c. (CITY, TOWN, OR TOWNSHIP): Lewiston (COUNTY): nezPerce 351 (STATE): Idaho 13
21d. TIME OF INJURY: (Month) Dec (Day) 10 (Year) 1967 (Hour) 11:00 1
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? she rented motel room then with door locked took overdose of pills.

22. *I hereby certify that I attended the deceased from* XXX, 19___, *to* ___, 19___, *that I last saw the deceased alive on* ___, 19___, *and that death occurred at* XXX *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Ducloss 383 — (Degree or title): Coroner 4
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 20 dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify): removal 3
24b. DATE: 12/11/67
24c. NAME OF CEMETERY OR CREMATORY: St. Maries
24d. LOCATION (City, town, or county) (State): St. Maries, Idaho

DATE REC'D BY LOCAL REG.: 12-11-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Andrew H. Vassar — LICENSE NO.: E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency — Public Health Service — Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 22 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 28 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 10 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5601
Local Reg. No. 301
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 304
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
STAY (in this place) 4 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 255 Garfield
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Pomeroy
d. STREET ADDRESS (If rural, give location) 696 Columbia Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	FRED	CLAY	ROMMEL		12	12	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	8-1-1894	73				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (Ret.) 04
10b. KIND OF BUSINESS OR INDUSTRY Wheat Farm
11. BIRTHPLACE (State or foreign country) Washington
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Christian H. Rommel — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Ellen Anna Smith — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 533-36-3878A
17. INFORMANT'S OWN SIGNATURE Mrs Fred Rommel — ADDRESS Pomeroy, Wn.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) PNEUMONIA (LOBAR) — INTERVAL BETWEEN ONSET AND DEATH 2 wks

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hemolytic Anemia — 2 yrs

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Dec 8, 1967, *to* Dec 12, 1967, *that I last saw the deceased alive on* Dec 12 1967, *and that death occurred at* 5:55 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	MD	Lewiston Idaho	12/18/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal-Burial	12-15-67	City	Pomeroy, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR	ADDRESS
12-19-67	Lynette Knott	Andy Reinland, Jr.	Pomeroy, Wash.

Federal Security Agency
United States Public Health Service

Form DPH-40021

JAN 1 1 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAY 1 4 1971

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

State File No. 5602
Local Reg. No. 306
Reg. Dist. No. 220

Certificate of Death

STATE OF IDAHO

BIRTH NO.

RECEIVED JAN 10 1968 Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 351 Nez Perce 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston

c. LENGTH OF STAY (in this place) DOA

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE 13 Idaho 350

b. COUNTY Nez Perce

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston (Orchards)

d. STREET ADDRESS (If rural, give location) 916 Preston Ave.

3. NAME OF DECEASED (Type or Print)

a. (First) LEROY

b. (Middle) MARION

c. (Last) CALLAHAN

4. DATE OF DEATH (Month) (Day) (Year) 12 December 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH 2 May 1912

9. AGE (In years last birthday) 55 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic 21

10b. KIND OF BUSINESS OR INDUSTRY Auto

11. BIRTHPLACE (State or foreign country) Driggs, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Leroy Isaac Callahan — BIRTHPLACE Arkansas

14. MOTHER'S MAIDEN NAME Myrtle Vaughn — BIRTHPLACE Mississippi

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 09 7956

17. INFORMANT'S OWN SIGNATURE Marlyn D. Callahan — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

8124

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Shock & Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH monents

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Scull fractures

DUE TO (c) auto-ped. accident

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Street, near home 04

21c. (CITY, TOWN, OR TOWNSHIP) 13 **(COUNTY)** 350 **(STATE)** Lewiston (Orchards) NezPerce Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12 Dec 1967 6:30PM 2

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ 2

21f. HOW DID INJURY OCCUR? Auto struck the Pedestrian while walking along street near his home.

22. *I hereby certify that I attended the deceased from - - - - - 19 - to - - - - - 19 -, that I last saw the deceased alive on - - - - - 19 -, and that death occurred at* 6:30PM *m., from the causes and on the date stated above.*

23a. SIGNATURE Wilfred J. Duclos — 583 (Degree or title) NezPerceCo.Coroner 4

23b. ADDRESS Lewiston, Idaho

23c. DATE SIGNED 14 Dec 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1

24b. DATE 15 Dec 1967

24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-22-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER L E DeBaum — Malcom's Brower-Wann Memorial Chapel — LICENSE NO. E-295

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5603
Local Reg. No. 302
Reg. Dist. No. 220

Certificate of Death

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 350 NezPerce 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lapwai (Rural)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY NezPerce 350
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lapwai
d. STREET ADDRESS (If rural, give location) Rural

3. NAME OF DECEASED (Type or Print)
a. (First) Elizabeth
b. (Middle)
c. (Last) Samuels

4. DATE OF DEATH (Month) Dec (Day) 14th (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 9-17-01
9. AGE (In years last birthday) 66 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none 00
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Montana
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME no record — BIRTHPLACE
14. MOTHER'S MAIDEN NAME No record — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. none
17. INFORMANT'S OWN SIGNATURE Betty Jean Samuels — ADDRESS Lapwai, Idaho.

9258

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Suffocation — INTERVAL BETWEEN ONSET AND DEATH: moments

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Acc. 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Indian Sweathouse 19
21c. (CITY, TOWN, OR TOWNSHIP) 13 Lapwai, Idaho — (COUNTY) 350 NezPerce — (STATE) Idaho

21d. TIME OF INJURY (Month) Dec (Day) 14 (Year) 67 (Hour) 2:30PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? didn't ger out of sweathouse in time and suffocated due to steam

22. *I hereby certify that I attended the deceased from* 2 ~~xxxx~~, 19__, *to* ____, 19__, *that I last saw the deceased alive on* ~~xxxxx~~, 19__, *and that death occurred at* ~~xxx~~ *m., from the causes and on the date stated above.*

23a. SIGNATURE Wilfred J. Duclos 583 (Degree or title) Coroner 4
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED 20 Dec. 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 18, 67
24b. DATE Dec. 18 1967
24c. NAME OF CEMETERY OR CREMATORY Arrow Idaho.
24d. LOCATION (City, town, or county) Arrow, Idaho, (State)

DATE REC'D BY LOCAL REG. 12-19-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER V. Vassar — LICENSE NO. E297
FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JUL 18 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by ~~Physician~~ coroner This woman entered the sweathouse the evening of the 13th and undoubtedly died then but was not found till the following day which was used as time of death.

Certificate of Death

STATE OF IDAHO

State File No. 5604
Local Reg. No. 298
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JAN 10 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 350 Nez Perce 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
LENGTH OF STAY IN (City) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston Manor 318

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 351
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston [redacted]
d. STREET ADDRESS (If rural, give location) 102 18th. Ave.

3. NAME OF DECEASED (Type or Print): a. (First) Carl b. (Middle) F. c. (Last) Jockheck

4. DATE OF DEATH: (Month) 12 (Day) 16 (Year) 1967

5. SEX: male
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2
8. DATE OF BIRTH: March 5, 1882
9. AGE (In years last birthday): 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): merchant 22
10b. KIND OF BUSINESS OR INDUSTRY: Meat Market
11. BIRTHPLACE (State or foreign country): Osnabruck Germany
12. CITIZEN OF WHAT COUNTRY? US
13. FATHER'S NAME: Ferdinand Jockheck — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: no record — BIRTHPLACE: Germany
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: None?
17. INFORMANT'S OWN SIGNATURE: [signature] ADDRESS: W.Hartford Conn.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized Arteriosclerosis.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on* 12/14/67, *and that death occurred at* 9:52 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 160 (Degree or title)
23b. ADDRESS Lewiston Idaho
23c. DATE SIGNED 12/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify): cremation
24b. DATE: 12-20-1967
24c. NAME OF CEMETERY OR CREMATORY: Hazen-Jaeger Funeral Home
24d. LOCATION (City, town, or county) (State): Spokane, Washington

DATE REC'D BY LOCAL REG.: 12-18-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Andrew H Vassar — LICENSE NO.: E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5605
Local Reg. No. 300
Reg. Dist. No. 220

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 350 Nez Perce 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
c. LENGTH OF STAY (in this place) 1 year
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Somerville Home 131

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 350
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston, Orchards
d. STREET ADDRESS (If rural, give location) Somerville Home

3. NAME OF DECEASED (Type or Print)
a. (First) Jesse Strickland
b. (Middle)
c. (Last)

4. DATE OF DEATH (Month) (Day) (Year) Dec. 17, 1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married 1
8. DATE OF BIRTH July 27, 1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer 06
10b. KIND OF BUSINESS OR INDUSTRY general
11. BIRTHPLACE (State or foreign country) Nebraska
12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME no record — BIRTHPLACE
14. MOTHER'S MAIDEN NAME no record — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no record
17. INFORMANT'S OWN SIGNATURE V. Vassar — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

3318

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable cerebral vascular accident — INTERVAL BETWEEN ONSET AND DEATH: about 1 week

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*
DUE TO (b)
DUE TO (c) Generalized arteriosclerosis — 3 days

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Hypertension

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* May, 1962, *to* Dec 17, 1967, *that I last saw the deceased alive on* Nov 8, 1967, *and that death occurred at* 8:15 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE J. W. Eastwood MD 152 (Degree or title) 1
23b. ADDRESS Lewiston Idaho
23c. DATE SIGNED 12/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial 1
24b. DATE Dec. 19, 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-19-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER V. Vassar
LICENSE NO. E297

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5606
Local Reg. No. 303
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JAN 10 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 NezPerce 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 3weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchard Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 351 NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1227-Idaho St

3. NAME OF DECEASED (Type or Print) a. (First) John b. (Middle) c. (Last) Mock

4. DATE OF DEATH (Month) Dec. (Day) 17, (Year) 1967

5. SEX male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH 4-1-1891

9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor 06

10b. KIND OF BUSINESS OR INDUSTRY General

11. BIRTHPLACE (State or foreign country) Springport, Mich.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME no record BIRTHPLACE

14. MOTHER'S MAIDEN NAME no record BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) ?

16. SOCIAL SECURITY NO. 371-28-2860-A

17. INFORMANT'S OWN SIGNATURE Home Records ADDRESS Vassar. Lewiston Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Probable congestive failure — INTERVAL BETWEEN ONSET AND DEATH: a few days

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b) arteriosclerotic heart disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.* Carcinoma of Prostate, senile confusion, Decubitus ulcer

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-8, 1967, *to* 12-17, 1967, *that I last saw the deceased alive on* 12-5, 1967, *and that death occurred at* 12:01 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE 152 (Degree or title) **23b. ADDRESS** Lewiston Idaho **23c. DATE SIGNED** 12/23/67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal **24b. DATE** 12-18-67 **24c. NAME OF CEMETERY OR CREMATORY** Albion, Mich. **24d. LOCATION** (City, town, or county) (State) Albion, Mich.

DATE REC'D BY LOCAL REG. 12-21-67 **REGISTRAR'S SIGNATURE** Lynette Knott

25. EMBALMER Andrew F. Vassar **LICENSE NO.** E 315

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 10 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5607
Local Reg. No. 308
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 350 Nez Perce 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3813-16th St. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 350
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
d. STREET ADDRESS (If rural, give location) 3813-16th St.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Bernard	S	Heywood	Dec. 18, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	If under 1 year: Months / Days	If under 24 hrs.: Hours / Min.
male	white	married 3	Oct. 26, 1917	50		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Physician 14	Medicine	Thatcher, Arizona	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J. N. Heywood	Utah	no record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes Korean conflict	527-09-8072	Mrs Bernard S. Heywood	Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a)	Acute ~~chronic~~ pancreatitis	2 weeks.
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Chronic pancreatitis	7 yrs.
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Pancreatic Cyst.	7 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Feb. *, 19* 67 *, to* Dec. *, 19* 67 *, that I last saw the deceased alive on* 13 Dec. *, 19* 67 *, and that death occurred at* 5 a *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature] 496 MD	Lewiston, Idaho	21 Dec. 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	Dec. 22, 1967	Lewis-Clark Memorial Gardens	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-26-67	Lynette Knott	V. Vassar	E297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

DUTIES:

JAN 1 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 6 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5608
Local Reg. No. 307
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JAN 10 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 251
b. COUNTY Nez Perce 302
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 3317 - 11th Street

3. NAME OF DECEASED (Type or Print)
a. (First) NELLIE
b. (Middle) MAY
c. (Last) ROSS

4. DATE OF DEATH (Month) (Day) (Year) 20 December 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 26 March 1893

9. AGE (In years last birthday) 74 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Bronson, Kansas

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert F. Stevenson
BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME Sarah Johnson
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 09 3640 B

17. INFORMANT'S OWN SIGNATURE Willard Ross
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Aortic & Mitral Stenosis — INTERVAL BETWEEN ONSET AND DEATH many yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Arteriosclerosis — yrs
DUE TO (c) acute congestive failure — 15 min

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

4210

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 6:20 PM., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 160

23b. ADDRESS Lewiston Idaho

23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 23 Dec 1967

24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-22-67

REGISTRAR'S SIGNATURE Lynette Knoll

25. EMBALMER K H Malcom
Malcom's Brower-Wann Memorial Chapel
LICENSE NO. E-376

FIRM NAME:

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 1 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5609
Local Reg. No. 309
Reg. Dist. No. 220

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 351 Nez Perce 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (in this place): 3 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 1602 - 18th Street

3. NAME OF DECEASED (Type or Print)
a. (First): CAREY
b. (Middle): WILSON
c. (Last): CARNES

4. DATE OF DEATH (Month) (Day) (Year): 21 December 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 1 January 1899
9. AGE (In years last birthday): 68 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman 24
10b. KIND OF BUSINESS OR INDUSTRY: Auto
11. BIRTHPLACE (State or foreign country): Minerva, Ohio
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Joseph Carnes — BIRTHPLACE: Ireland
14. MOTHER'S MAIDEN NAME: Emma Pennock — BIRTHPLACE: Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): WW-1 — (If yes, give war or dates of service): 3
16. SOCIAL SECURITY NO.: 532 09 9936
17. INFORMANT'S OWN SIGNATURE: Linda Hopkins — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH 5871
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) advanced chronic pancreatitis with probable hemolytic jaundice

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) advanced arteriosclerotic
DUE TO (c) cardiovascular disease

INTERVAL BETWEEN ONSET AND DEATH: 2 months

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 12 Dec 67
19b. MAJOR FINDINGS OF OPERATION: Chronic pancreatitis
20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7 Dec, 1967, *to* 21 Dec, 1967, *that I last saw the deceased alive on* 21 Dec, 1967, *and that death occurred at* 2:55 PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): David W. Hewson Dvd MD 227
23b. ADDRESS: 307 St John's Way
23c. DATE SIGNED: 22 Dec 1967

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 23 Dec 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-28-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: L E DeBaun
LICENSE NO.: E-295

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Malcom's Brower-Wann Memo. Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 11 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

67-12420

RECEIVED

JAN 10 1968

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5610
Local Reg. No. 318
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 351 Nes Perse 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
LENGTH OF STAY (in this place): 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: 48 Washington
b. COUNTY: 555 Asotin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Clarkston
d. STREET ADDRESS (If rural, give location): 1012 20th Ave.

3. NAME OF DECEASED (Type or Print)
a. (First): DUANE
b. (Middle): ALAN
c. (Last): ANDERSEN

4. DATE OF DEATH (Month) (Day) (Year): Dec. 22, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Never Married
8. DATE OF BIRTH: Dec. 19, 1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days 3; IF UNDER 24 HRS. Hours 13 Min. 8

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE 02
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (State or foreign country): Lewiston, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Jerry E. Andersen
BIRTHPLACE: Bremerton, Wash.
14. MOTHER'S MAIDEN NAME: Carolyn Carssow
BIRTHPLACE: Klamoth Falls, Ore.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT'S OWN SIGNATURE: Jerry E. Andersen By David Crymes
ADDRESS:

18. CAUSE OF DEATH 776X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) prematurity

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19__, *to* 12, 22, 1967, *that I last saw the deceased alive on* 12, 19, 1967, *and that death occurred at* 2:30 P.m., *from the causes and on the date stated above.*

23a. SIGNATURE: John E. Carssow M.
083 (Degree or title)
23b. ADDRESS: Lewiston Idaho
23c. DATE SIGNED: 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal 3
24b. DATE: Dec. 23, 1967
24c. NAME OF CEMETERY OR CREMATORY: Vineland Cemetery
24d. LOCATION (City, town, or county) (State): Clarkston, Washington

DATE REC'D BY LOCAL REG.: 1-2-68
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: W. C. Merchants
LICENSE NO.: 240-03-472

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5611
Local Reg. No. 316
Reg. Dist. No. 220

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 2 wks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 13 Idabo 351
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 3531 - 9th Street

3. NAME OF DECEASED (Type or Print)
a. (First) CLARENCE
b. (Middle) ALBERT
c. (Last) HOSLEY (Sr.)

4. DATE OF DEATH (Month) (Day) (Year) 23 December 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH 18 April 1891
9. AGE (In years last birthday) 76 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Worker 17
10b. KIND OF BUSINESS OR INDUSTRY Lumber
11. BIRTHPLACE (State or foreign country) Neodesha, Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert H osley — BIRTHPLACE no record
14. MOTHER'S MAIDEN NAME Mae Lisco — BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. no record
17. INFORMANT'S OWN SIGNATURE Mae Dugger — ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

0821

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Viral Meningitis

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Unknown.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION None
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 66 *to* December 23, 19 67, *that I last saw the deceased alive on* Dec 23rd, 19 67, *and that death occurred at* 2:11 AM, *from the causes and on the date stated above.*

23a. SIGNATURE 029 (Degree or title) Jacob E Baldwin MD
23b. ADDRESS 1 1522 17th Lewiston Idaho
23c. DATE SIGNED 12/27/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 26 Dec 1967
24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-29-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER K. H. Malcom
LICENSE NO. E-376

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Malcom'sBrower-WannMemo.Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 1 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5612
Local Reg. No. 317
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JAN 10 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 351 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (in this place) 2 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Josephs Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 351 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 3640 - 17th Street

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) LOUIS c. (Last) JONES

4. DATE OF DEATH (Month) (Day) (Year) 24 December 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 1 September 1877

9. AGE (In years last birthday) 90 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conductor 10

10b. KIND OF BUSINESS OR INDUSTRY Railroad

11. BIRTHPLACE (State or foreign country) Auburn, Oregon

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Jessie Jones
BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME Sarah ?
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 540 10 4243A

17. INFORMANT'S OWN SIGNATURE Sally Jones ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia. — INTERVAL BETWEEN ONSET AND DEATH 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Prostatitis
DUE TO (c) Infirmities of age.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Blindness & is Deaf.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug, 1954 to Dec, 1967, that I last saw the deceased alive on Dec 24, 1967, and that death occurred at 11:04AM, from the causes and on the date stated above.

23a. SIGNATURE (Degree or title) 509 MD

23b. ADDRESS 939 Bryden LEWISTON, IDAHO

23c. DATE SIGNED 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 28 Dec 1967

24c. NAME OF CEMETERY OR CREMATORY Lewis-Clark Memo. Gard.

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-29-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER K H. Malcom

LICENSE NO. E-376

FIRM NAME: Malcom's Brower-Wann Memo. Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 1 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5613
Local Reg. No. 311
Reg. Dist. No. 220

RECEIVED JAN 10 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 361 Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
c. LENGTH OF STAY (in this place) 6 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Lewiston Manor 318

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 310
b. COUNTY Lewis
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Craigmont
d. STREET ADDRESS (If rural, give location) rural

3. NAME OF DECEASED (Type or Print)
a. (First) Bertha
b. (Middle) Jane
c. (Last) Moore

4. DATE OF DEATH (Month) (Day) (Year) Dec. 27, 1967

5. SEX female

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH April 21, 1881

9. AGE (In years last birthday) 86
If UNDER 1 YEAR Months / Days
If UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife 01

10b. KIND OF BUSINESS OR INDUSTRY at home

11. BIRTHPLACE (State or foreign country) Soldiers Grove, Wisconsin

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Martin Hicks
BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME no record
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. no record

17. INFORMANT'S OWN SIGNATURE John W Moore
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH 4200
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Congestive Failure — INTERVAL BETWEEN ONSET AND DEATH: Months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) A H Dis — Years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Senility

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/22, 1967, *to* 12/27, 1967, *that I last saw the deceased alive on* 12/20, 1967, *and that death occurred at* 1145 A *m., from the causes and on the date stated above.*

23a. SIGNATURE George Allen Thompson 531 (Degree or title)

23b. ADDRESS 917 - 6th St Clarkston, Wn

23c. DATE SIGNED 1/2/68

24a. BURIAL, CREMATION, REMOVAL (Specify) burial

24b. DATE Dec. 30, 1967

24c. NAME OF CEMETERY OR CREMATORY Normal Hill cemetery

24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-29-67

REGISTRAR'S SIGNATURE Lynette Knott

25. EMBALMER D. Vassar

LICENSE NO. E297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 1 1 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5614
Local Reg. No. 310
Reg. Dist. No. 220

RECEIVED JAN 10 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 351 NezPerce 303
b. CITY OR TOWN Lewiston, c. LENGTH OF STAY (in this place) 3days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 350 b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lapwai (Rural)
d. STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH	(Month)	(Day)	(Year)
	Floyd	R.	Lasswell		Dec	27	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Aug. 20, 1886	81				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	Se VR	Yakima, Wash.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Lasswell	Ore	No record	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		No record	X Lynn H. Lasswell	Lapwai, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4331

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Heart Failure (Atrial Fibrillation) — INTERVAL BETWEEN ONSET AND DEATH: 4 Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11/12, 1958, *to* 11/26, 1967, *that I last saw the deceased alive on* 12/26, 1967, *and that death occurred at* 4:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
V. M. Lover MD 503	Lewiston, Idaho. (Rural)	12-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-30-67	Lewis-Clark Memorial Gardens	Lewiston, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-29-67	Lynette Knott	Andrew F. Vassar	E-315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5615
Local Reg. No. 312
Reg. Dist. No. 220

Certificate of Death

RECEIVED
JAN 10 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 351 NezPerce 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 351
b. COUNTY: NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston
d. STREET ADDRESS (If rural, give location): 415-7th Ave

3. NAME OF DECEASED (Type or Print)
a. (First): Freda
b. (Middle): C
c. (Last): Erickson

4. DATE OF DEATH (Month) Dec (Day) 27 (Year) 1967

5. SEX: female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3
8. DATE OF BIRTH: 8-27-1891
9. AGE (In years last birthday): 76 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): 01 house wife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Dresden, Germany
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Fritz Raithel — BIRTHPLACE: Germany
14. MOTHER'S MAIDEN NAME: Bertha Weidenmuller — BIRTHPLACE: Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 518-56-0673
17. INFORMANT'S OWN SIGNATURE: X Carl P. Erickson — ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4210

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Mitral Insufficiency — 3 yrs
DUE TO (c): Cardiac Insufficiency — 8 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: None

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1960, 19__, *to* Dec 27, 1967, *that I last saw the deceased alive on* Dec 27, 1967, *and that death occurred at* 11 20 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Joseph E Boedeker Nel 1 022 (Degree or title)
23b. ADDRESS: N22 17th St Lewiston Idaho
23c. DATE SIGNED: 12/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 12-29-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: Andrew F. Vassar
LICENSE NO.: E315

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5616
Local Reg. No. 314
Reg. Dist. No. 220

BIRTH NO.

Bureau of Vital Statistics

JAN 10 1968

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 35/ NezPerce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
c. LENGTH OF STAY (In this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 35/
b. COUNTY NezPerce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 927-15th Ave

3. NAME OF DECEASED (Type or Print): a. (First) James; b. (Middle) C.; c. (Last) Martin

4. DATE OF DEATH: (Month) Dec (Day) 28 (Year) 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2

8. DATE OF BIRTH: Sept 1, 1885

9. AGE (In years last birthday): 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired 29

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Sherman City. Mich.

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: C.J. Martin — BIRTHPLACE: Mich.

14. MOTHER'S MAIDEN NAME: No record — BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): (If yes, give war or dates of service) no

16. SOCIAL SECURITY NO.: 518-03-9263A

17. INFORMANT'S OWN SIGNATURE: Dorothy M. Jones — ADDRESS: Lewiston, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5705

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 Days.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Intestinal obstruction — 10 days

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct. 30, *19* 67, *to* Dec. 28, *19* 67, *that I last saw the deceased alive on* Dec. 27, *19* 67, *and that death occurred at* 1:34 a *m., from the causes and on the date stated above.*

23a. SIGNATURE: John F. Bauer. 028 (Degree or title) M.D.

23b. ADDRESS: 347 St. John's Way, Lewiston, Ida.

23c. DATE SIGNED: 12/29/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-30-67

24c. NAME OF CEMETERY OR CREMATORY: Normal Hill Cemetery

24d. LOCATION (City, town, or county) (State): Lewiston, Idaho.

DATE REC'D BY LOCAL REG.: 12-29-67

REGISTRAR'S SIGNATURE: Lynette Knott

25. EMBALMER: Andrew H. Vassar.

LICENSE NO.: E 315

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5617
Local Reg. No. 315
Reg. Dist. No. 220

RECEIVED JAN 10 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 Nez Perce 203
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
LENGTH OF STAY (In this place) 2 1/2 mos.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Orchards Nursing Home 174

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston
d. STREET ADDRESS (If rural, give location) 1525 - 12th Street

3. NAME OF DECEASED (Type or Print)
a. (First) LILLIE
b. (Middle) MAE
c. (Last) WILSON

4. DATE OF DEATH (Month) (Day) (Year) 28 December 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH 25 February 1889

9. AGE (In years last birthday) 78
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Freeman, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert Anderson
BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME Sarah Tuttle
BIRTHPLACE no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519 24 8847 A

17. INFORMANT'S OWN SIGNATURE Blanche Ryther
ADDRESS Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Heart failure
DUE TO (c) Mitral Insufficiency

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Infirmities of Age
Hypostatic

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct, 1954, *to* Dec, 1967, *that I last saw the deceased alive on* Dec 27 1967, *and that death occurred at* 5:15AM *m., from the causes and on the date stated above.*

23a. SIGNATURE Dan Glover, 507 (Degree or title)
23b. ADDRESS Lewiston, Idaho
23c. DATE SIGNED

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 30 Dec 1967
24c. NAME OF CEMETERY OR CREMATORY Normal Hill Cemetery
24d. LOCATION (City, town, or county) (State) Lewiston, Idaho

DATE REC'D BY LOCAL REG. 12-29-67
REGISTRAR'S SIGNATURE Lynette Knott
25. EMBALMER K. H. Malcom
LICENSE NO. E-376

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME Malcom's Brower-Wann Memorial Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5618
Local Reg. No. 2
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JAN 17 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 361 Nez Perce 306
b. CITY OR TOWN (If outside corporate limits, write township) Lewiston
DURATION OF STAY (in this place) 6 days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) St. Joseph's Hospital 128

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 350
b. COUNTY Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Lewiston Orchards
d. STREET ADDRESS (If rural, give location) 3423 15th Street

3. NAME OF DECEASED (Type or Print): a. (First) Stanley b. (Middle) J c. (Last) Willis

4. DATE OF DEATH (Month) (Day) (Year): Dec. 28, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	July 9, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
mechanic 21	auto [illegible]	Pennsylvania	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Stanley Koscinski	no record	no record	no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW I 3	no record	Opal E Willis	Lewiston, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	CVA	
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic vascular disease	
DUE TO (c)	Hypertension	
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/25, 1967, *to* 12/28, 1967, *that I last saw the deceased alive on* 12/28, 1967, *and that death occurred at* 8:05PM., *from the causes and on the date stated above.*

23a. SIGNATURE	23b. ADDRESS	23c. DATE SIGNED
036 (Degree or title) MD	626 5th Ave. Lewiston, Idaho	1/4/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1-5-68	Normal Hill	Lewiston, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-5-68	Lynette Knott	V Vassar	E297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

O. V. Saxton
Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 18 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 26 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 20 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 4 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5619
Local Reg. No. 319
Reg. Dist. No. 220

RECEIVED JAN 10 1968 Vital Statistics Bureau of Health

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 35 NezPerce
b. CITY OR TOWN Lewiston
d. FULL NAME OF HOSPITAL OR INSTITUTION 1827 8th St

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 35 NezPerce
c. CITY OR TOWN Lewiston
d. STREET ADDRESS (If rural, give location) 1827-8th Ave

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Gertrude		Thompson	Dec 29 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	April 7, 1889	78		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife 01	at home	New Buffalo, Mich.	U. S. A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Louis H. Shubert	South Bend, Indiana.	Mary Ann Culp	Elkhart, Indiana.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		no record	Maurice H Thompson	Lewiston, Idaho.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

9030

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Fracture Subtrochanteric Hip Right — 6/20/67

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
6/20/67	as above	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
1	Home 01	Lewiston 23	Nez Perce 35	Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
6 20 67 11 A.M.	WHILE AT WORK ☐ NOT WHILE AT WORK ☒	

22. *I hereby certify that I attended the deceased from* Feb 14, 1965 *to* Dec 29, 1967, *that I last saw the deceased alive on* 9-30, 1967, *and that death occurred at* 7 [illegible] m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
W S Douglas 144 MD	307 St John Way Lewiston Idaho	1/2/68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Byrial	Jan. 2, 1968	Normal Hill Cemetery	Lewiston, Idaho.

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-2-68	Lynette Knott	Andrew F. Vassar	E 315

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5620
Local Reg. No. 24
Reg. Dist. No. 530

Certificate of Death

RECEIVED
JAN 16 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 360 Oneida 179
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad
c. LIMITS OF STAY (in this place) 79 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Oneida Hospital 132

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 360
b. COUNTY Oneida
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Malad
d. STREET ADDRESS (If rural, give location) 235 Bannock St.,

3. NAME OF DECEASED (Type or Print)
a. (First) GOMER
b. (Middle) JONES
c. (Last) EVANS

4. DATE OF DEATH (Month) (Day) (Year) December 29, 1967

5. SEX Male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Sept. 5, 1888
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) service sta. operator
10b. KIND OF BUSINESS OR INDUSTRY 06 petroleum
11. BIRTHPLACE (State or foreign country) Malad, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William W. Evans — BIRTHPLACE Wales
14. MOTHER'S MAIDEN NAME Mary Jones — BIRTHPLACE Wales

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) 518-09-2054
16. SOCIAL SECURITY NO. 518-09-2054
17. INFORMANT'S OWN SIGNATURE Raiford G. Benson — ADDRESS Malad, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Arterio sclerotic heart disease

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetis mellitus
DUE TO (c) Glomerulo-nephritis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1964, *to* Dec 29, 1967, *that I last saw the deceased alive on* Dec 29, 1967, *and that death occurred at* 10:15P m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 315 (Degree or title) M.D.
23b. ADDRESS Malad Idaho
23c. DATE SIGNED 12-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 1-2-68
24c. NAME OF CEMETERY OR CREMATORY Malad City Cemetery
24d. LOCATION (City, town, or county) (State) Malad, Idaho

DATE REC'D BY LOCAL REG. 1-2-68
REGISTRAR'S SIGNATURE Ruth G. Sweeten
25. EMBALMER Raiford G. Benson — LICENSE NO. E-351

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Benson Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED.. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 2 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5621
Local Reg. No. 392
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 370 Owyhee 206
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale | LENGTH OF STAY (in this place) 6 mo
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Homedale Nursing Home 305

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 370 Owyhee
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Homedale
d. STREET ADDRESS (If rural, give location) City

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Charles	Melvin	Hoyt	Dec. 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	May 5, 1881	86	7	11		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer 04	Retired	Lenora Norton Co. Kansas	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Edmond R. Hoyt	Clinton Co. Mich.	Mary H. Boone	Rawley, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No		515-01-9638	Mrs Charley Bosworth	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 3348 Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 4 yrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* Sept, 1967, *to* Dec 16, 1967, *that I last saw the deceased alive on* Dec 15, 1967, *and that death occurred at* 2.4 m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
570	MD		12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 20, 1967	Marsing-Homedale	Homedale, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 26 '67	Andrew Warfield	Leonard C. Flaniff	E-481

FIRM NAME: Homedale's Flaniff Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5622
Local Reg. No. 68
Reg. Dist. No. 330

RECEIVED DEC 13 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Fruitland
c. LENGTH OF STAY (in this place): 11 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rt. 1, 5 mi. So. Fruitland

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Fruitland
d. STREET ADDRESS (If rural, give location): Rt. 1, 5 mi. So. Fruitland

3. NAME OF DECEASED (Type or Print): a. (First) CHARLOTTE; b. (Middle) ALLRED; c. (Last) MALEAU

4. DATE OF DEATH: (Month) December (Day) 4 (Year) 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 5, 1900

9. AGE (In years last birthday): 67
IF UNDER 1 YEAR: Months –; Days –
IF UNDER 24 HRS.: Hours –; Min. –

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Afton, Wyoming

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: B. H. Allred
BIRTHPLACE: Idaho

14. MOTHER'S MAIDEN NAME: Charlotte Pead
BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service): – –

16. SOCIAL SECURITY NO.: 519-60-1474

17. INFORMANT'S OWN SIGNATURE: William D. Maleau
ADDRESS: Fruitland Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 10 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Arteriosclerotic Coronary artery disease — 1 year
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Arteriosclerotic cardiovascular Dis. — 1 year

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Oct 2, 1967, *to* Dec 4, 1967, *that I last saw the deceased alive on* Nov. 15, 1967, *and that death occurred at* 9:00 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. L. Farnell, M.D. 082 (Degree or title)
23b. ADDRESS: Payette, Idaho
23c. DATE SIGNED: 12/6/67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 12/7/67
24c. NAME OF CEMETERY OR CREMATORY: Park View Cemetery
24d. LOCATION (City, town, or county) (State): New Plymouth Idaho

DATE REC'D BY LOCAL REG.: 12/7/67
REGISTRAR'S SIGNATURE: Roberta E. Shaffer
25. EMBALMER: Keith M. Jensen
LICENSE NO.: E-517
FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUN 12 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to
(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5623
Local Reg. No. 69
Reg. Dist. No. 330

RECEIVED DEC 26 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY 380 Payette

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth

c. LENGTH OF STAY (in this place) Years

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 118 W. McKinley 500

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 380

b. COUNTY Payette

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth

d. STREET ADDRESS (If rural, give location) 118 W. McKinley

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Arthur	Bernard	Meyer	December 14, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	December 23, 1920	46	-	-	-	-

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Business Manager 26	Building Supplies	New Plymouth, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ernst Meyer	Nebraska	Florence Ackerman	Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW II 4	518-22-0112	Mrs Art Meyer	New Plymouth, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Accute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
- - - - - -	- - - - - - - - - -	- - - - - - - - - - - - - - - - - -

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
- - - - - - - m.		- - - - - - - - - - - - - - - - - -

22. *I hereby certify that I attended the deceased from* Investigated *to* Dec. 14, 1967, *that I last saw the deceased alive on* [illegible] *and that death occurred at* 8:05A. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Hardy Hudson. 583	Coroner 4	Payette, Idaho	12/15/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/16/67	Park View	New Plymouth Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/16/67	Roberta E. Shaffer	Marvin R. Riddle	E-515

FIRM NAME: SHAFFER-JENSEN MEMORY CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DEC 26 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 28 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5624
Local Reg. No. 70
Reg. Dist. No. 330

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 13 Mo.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Sanitarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 380
b. COUNTY Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
d. STREET ADDRESS (If rural, give location) 1019 3rd Ave S.

3. NAME OF DECEASED (Type or Print)
a. (First) John
b. (Middle) L.
c. (Last) Nevitt

4. DATE OF DEATH (Month) Dec (Day) 22 (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married 1
8. DATE OF BIRTH Oct. 25 1885
9. AGE (In years last birthday) 82 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician 21
10b. KIND OF BUSINESS OR INDUSTRY Electrical
11. BIRTHPLACE (State or foreign country) Montana
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Peter W. Nevitt — BIRTHPLACE Illinois
14. MOTHER'S MAIDEN NAME Ada Banes — BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes — (If yes, give war or dates of service) WW One 3
16. SOCIAL SECURITY NO. 063-097548
17. INFORMANT'S OWN SIGNATURE Wayne R. Smith Idaho — ADDRESS 809 3rd Ave S Payette Idaho

4500

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH 6 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April, 19 65 *to* 12/22/67, 19__, *that I last saw the deceased alive on* 12/15/67, 19__, *and that death occurred at* 6:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE Thomas W. Watts Jr. MD 553 (Degree or title)
23b. ADDRESS Payette, Idaho
23c. DATE SIGNED 12/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/27/67
24c. NAME OF CEMETERY OR CREMATORY Rosedale Memorial Garden
24d. LOCATION (City, town, or county) Payette (State) Idaho

DATE REC'D BY LOCAL REG. 12-26-67
REGISTRAR'S SIGNATURE Roberta E. Shaffer
25. EMBALMER Donald F. Brown
LICENSE NO. E-408

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Chapel of the Roses

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 3 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 15 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5625
Local Reg. No. 71
Reg. Dist. No. 330

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 380 Payette
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Payette
c. LENGTH OF STAY (in this place) 6 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Payette Valley Santarium 243

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 380 Payette
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) New Plymouth
d. STREET ADDRESS (If rural, give location) Route #2

3. NAME OF DECEASED (Type or Print) a. (First) JESSIE b. (Middle) ALBERTA c. (Last) HANCE

4. DATE OF DEATH (Month) (Day) (Year) Dec. 30, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH April 15, 1890

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME A. Scottie Muir — **BIRTHPLACE** Scotland

14. MOTHER'S MAIDEN NAME Carrie Titus — **BIRTHPLACE** Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 505-16-0726A

17. INFORMANT'S OWN SIGNATURE Jessie F. Stelling — **ADDRESS** New Plymouth Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute cerebral thrombosis with right hemiplegia — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized arteriosclerosis with — 10 yrs.
DUE TO (c) cerebral and cardiac ischemia

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Diabetes Mellitus — 20 yrs.

3332X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 28, 1967, *to* Dec. 30, 1967, *that I last saw the deceased alive on* Dec. 30, 1967, *and that death occurred at* 1:20 a m., *from the causes and on the date stated above.*

23a. SIGNATURE Geo E Davis 131 (Degree or title) MD

23b. ADDRESS New Plymouth, Idaho

23c. DATE SIGNED Jan 2 68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 1/2/1968

24c. NAME OF CEMETERY OR CREMATORY Park View Cemetery

24d. LOCATION (City, town, or county) (State) New Plymouth, Idaho

DATE REC'D BY LOCAL REG. 1/2/68

REGISTRAR'S SIGNATURE Roberta E. Shaffer

25. EMBALMER Keith M. Jensen — **LICENSE NO.** E-517

FIRM NAME: Shaffer-Jensen Memory Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5626
Local Reg. No. 22
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED JAN 4 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Power (390)
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
c. LENGTH OF STAY (in this place): (800)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home (Johnson St.) (600)

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Power (390)
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): American Falls
d. STREET ADDRESS (If rural, give location): Johnson Street

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JULIUS	A.	WINTER	Dec.	28,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Never married /	Nov. 18, 1885	82	1	0		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bureau of Land Mgmt. (8)	U. S. Gov.	Hutchinson County, S. Dakota Unknown	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Jakob Winter	Russia	Justina Martel	Russia

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-20-8982	x H. A. Winter	Am. Falls, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: Few min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Acute Coronary occlusion
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* [illegible] *saw the deceased* [illegible] *on* 12-28, 19 67, *and that death occurred at* 6:40p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Bud Kelly 583	Coroner 4	American Falls, Idaho	12-29-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	12-29-67	Menno Village Cemetery	Menno, South Dakota

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-2-68	Callene Hadfield	H. L. Davis	H. L. Davis E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5627
Local Reg. No. 29
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED
JAN 15 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 390 Power 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) American Falls
c. LENGTH OF STAY (in this place) 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Power County Hospital 137

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 390
b. COUNTY Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rockland
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) BIRTIE (BERT) b. (Middle) CARLYLE (C.) c. (Last) KELLY

4. DATE OF DEATH (Month) Dec. (Day) 30, (Year) 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Aug. 21, 1893
9. AGE (In years last birthday) 75 IF UNDER 1 YEAR Months 4 Days 9 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber- Merchant 21
10b. KIND OF BUSINESS OR INDUSTRY Barber shop- Store
11. BIRTHPLACE (State or foreign country) Calls Fort, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Robert C. Kelly
BIRTHPLACE Utah
14. MOTHER'S MAIDEN NAME Harriett May
BIRTHPLACE Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) WW 1 3
16. SOCIAL SECURITY NO. 519-36-6002
17. INFORMANT'S OWN SIGNATURE Mrs. Leona Kelly
ADDRESS Rockland, Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4281

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Massive Anterio-lateral and diaphragmatic coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 3 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Coronary sclerosis — 3 years

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 30, 1967 to Dec. 30, 1967, that I last saw the deceased alive on Dec. 30, 1967, and that death occurred at 12:25A., from the causes and on the date stated above.

23a. SIGNATURE H. L. Harris 203 (Degree or title) MD
23b. ADDRESS Americcan Falls, Idaho
23c. DATE SIGNED 12 2-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Rem. & Burial
24b. DATE Jan. 3, 1968
24c. NAME OF CEMETERY OR CREMATORY Valley View Cemetery
24d. LOCATION (City, town, or county) Rockland, (State) Idaho

DATE REC'D BY LOCAL REG. 1-8-68
REGISTRAR'S SIGNATURE Callene Hatfield
25. EMBALMER H. L. Davis
LICENSE NO. E-253

FIRM NAME: Davis Furniture & Mortuary, Inc.

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5628
Local Reg. No. 28
Reg. Dist. No. 500-602

BIRTH NO.

RECEIVED
JAN 15 1968
Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 390 Power 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Home
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Fairview 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 390
b. COUNTY: Power
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural (Fairview)
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
JAMES	CLEON	CHAPMAN	Dec.	31,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Aug. 1, 1910	57	4	30		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farmer, Ins. Agent	Farm Bureau Ins.	Warrick County, Indiana	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James W. Chapman	Indiana	Flora M. Cato	Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-14-8578	Mrs. Cleon Chapman	Am. Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Embolism of right ventricle & embolus into pulmonary — INTERVAL BETWEEN ONSET AND DEATH: 5 min

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Coronary insufficiency — One year
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
June 25, 1967	right coronary artery anastamosed with Mammary	YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* March 2, 19 65, *to* Dec. 9, 19 67, *that I last saw the deceased alive on* Dec. 9, 1967, *and that death occurred at* 9:00A m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. L. Harris	MD	American Falls, Idaho	1-4-68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	1-4-68	Fallsview Cemetery	American Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-10-68	Callie Fairfield	H. L. Davis	E-253

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Davis Furniture & Mortuary, Inc.

DUTIES:

JAN 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5629
Local Reg. No.
Reg. Dist. No.

67-12340

REC'D DEC 22 1967

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 2 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 401 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 141 110 West Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) CHARRLET
b. (Middle) L.
c. (Last) WALKER

4. DATE OF DEATH (Month) (Day) (Year) Dec. 3 1967

5. SEX Female
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH Dec. 3, 1967
9. AGE (In years last birthday) 0 — IF UNDER 1 YEAR: Months 0, Days 0 — IF UNDER 24 HRS.: Hours 2, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None 02
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Kellogg, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Mead Walker — BIRTHPLACE Montana
14. MOTHER'S MAIDEN NAME Shirley DuBois — BIRTHPLACE Montana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO. None
17. INFORMANT'S OWN SIGNATURE Mead Walker — ADDRESS Kellogg Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Prematurity — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3 December 1967, *to* 3 December 1967, *that I last saw the deceased alive on* 3 December, 1967, *and that death occurred at* 9:59 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE Robert H. Cordwell, M.D. 105 (Degree or title)
23b. ADDRESS Kellogg, Idaho
23c. DATE SIGNED 7 Dec 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg, Idaho

DATE REC'D BY LOCAL REG. 12/20/67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Donald Maisel — LICENSE NO. E452

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Maisel Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 216.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 11 1967 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5630
Local Reg. No. 78
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 417 Earle Ave. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location) 417 Earle Ave.

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Ellen	Elizabeth	Smith	12 - 3 - 67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Widowed 2	June 21, 1897	70		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife 01	Home	Wallace, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown		Unknown	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-38-2958	Wm L Smith	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-3-1967 *to* 12-3-1967, *that I last saw the deceased alive on* 12-3-1967, *and that death occurred at* 1:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. M. Peterson	M.D.	Wallace, Idaho	12-6-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 8, 1967	Riverside Cemetery	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 7, 1967	Wade L Cornell	Derrell J. Juelfs	E-518

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

DEC 1 1 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. ~~95~~631
Local Reg. No. ~~[illegible]~~ 99
Reg. Dist. No. 142

Certificate of Death

STATE OF IDAHO

RECEIVED DEC 22 1967 Bureau

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 505 Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 Kellogg Senior High School

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 401 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 128 West Mission

3. NAME OF DECEASED (Type or Print)
a. (First) THOMAS
b. (Middle) W.
c. (Last) BRAINARD

4. DATE OF DEATH (Month) (Day) (Year) Dec. 4, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married
8. DATE OF BIRTH July 22, 1950
9. AGE (In years last birthday) 17 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student 03
10b. KIND OF BUSINESS OR INDUSTRY School
11. BIRTHPLACE (State or foreign country) Kellogg, Idaho
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wayne Brainard — BIRTHPLACE Idaho
14. MOTHER'S MAIDEN NAME Helen Holcomb — BIRTHPLACE Wisconsin

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) None
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Wayne A. Brainard — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

9146

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Electric Shock (Electrocution) — INTERVAL BETWEEN ONSET AND DEATH few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) School 23
21c. (CITY, TOWN, OR TOWNSHIP) 23 **(COUNTY)** 401 **(STATE)** Kellogg, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-4-67 4:45 about 2 m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? Electrocuted in whirl pool bath

22. *I hereby certify that I attended the deceased from* 12-4-1967, *to* 12-4, 1967, *that I last saw the deceased alive on* 12-4, 1967, *and that death occurred at* about 4:45 P. m., *from the causes and on the date stated above.*

23a. SIGNATURE 414 (Degree or title) G. M. Peterson, M.D.
23b. ADDRESS Wallace, Idaho
23c. DATE SIGNED 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 7, 1967
24c. NAME OF CEMETERY OR CREMATORY Greenwood
24d. LOCATION (City, town, or county) Kellogg, Idaho (State)

DATE REC'D BY LOCAL REG. 12/20/67
REGISTRAR'S SIGNATURE Joe Irvine
25. EMBALMER Donald Maisel
LICENSE NO. E452

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: MAISEL FUNERAL CHAPEL

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 22 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 19 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED DEC 22 1967 Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5632
Local Reg. No. 100
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone Bureau 201
b. CITY OR TOWN Kellogg
c. LENGTH OF STAY (in this place) 5 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 400
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Smelterville
d. STREET ADDRESS (If rural, give location) 510 Washington

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	OLGA	MARIE	PETERS	Dec.	8,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Dec. 2, 1875	92				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Home	Finland	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Luhtala	Finland	Kaisa Porkholma	Finland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	519-64-1845	Otto E Peterson	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4208

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Hypostatic Pneumonia	10 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic Heart Disease	5 years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Anemia, Intermittent	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
		Kellogg	Shoshone	Idaho

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
			m.		

22. *I hereby certify that I attended the deceased from* 28 April, 1967 *to* 8 Dec, 1967, *that I last saw the deceased alive on* 8 Dec, 1967, *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Ken M. Whitesel	539 MD	Kellogg, Idaho	12 Dec 67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Dec. 9, 1967	Robert's Cemetery	Robert's, Montana

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/20/67	Joe Simms	Donald Maisel	E452

FIRM NAME: MAISEL FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 19 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 18 1967
Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5633
Local Reg. No. 80
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 402 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Home - Black Cloud 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 402 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Wallace
d. STREET ADDRESS (If rural, give location): Black Cloud

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Peter		Zanetti	Dec.	10	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	Nov. 14, 1902	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Part-owner 11	Construction	Idaho	USA

13. FATHER'S NAME — BIRTHPLACE

14. MOTHER'S MAIDEN NAME — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-01-9832	X Harriett Zanetti	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY Ooccur?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-10, 1967, *to* 12-10, 1967, *that I last saw the deceased alive on* 12-10, 1967, *and that death occurred at* 7:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. M. Peterson, M.D.	Wallace, Idaho	12-12-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 12, 1967	Nine Mile Cemetery	Wallace Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-12-67	Dale Cornell	Dale L. Cornell	E-406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 19 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED DEC 22 1967 Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5634
Local Reg. No. 101
Reg. Dist. No. 142

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) County Nursing Home 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 48 Washington
b. COUNTY 555 Spokane
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Deer Park
d. STREET ADDRESS (If rural, give location) Deer Park

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	JOHN	J.	HICKEY	Dec.	11,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	Jan. 11, 1878	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Ret. Lumberman 17	Lumber	Pennsylvania	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Hickey	Ireland	Hannah McGrath	Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None	536-03-5107	James L. Hickey	

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Cerebral Hemorrhage	7 days
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerosis	Several years
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Jan 1, 1966, *to* 12-11, 1967, *that I last saw the deceased alive on* 12-11, 1967, *and that death occurred at* 5:40 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
G. M. Peterson, M.D. 414	Wallace, Idaho	12-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 14, 1967	Holy Cross	Spokane, Washington

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12/20/67	Joe Devine	Harold Maisel	E452

FIRM NAME: MAISEL'S FUNERAL CHAPEL

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

DEC 27 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items [illegible] inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for~~ less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5635
Local Reg. No. 82
Reg. Dist. No. 140

BIRTH NO.

DEC 20 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Osburn
d. STREET ADDRESS (If rural, give location) 603 E. Larch Street

3. NAME OF DECEASED (Type or Print) a. (First) Charles b. (Middle) Oscar c. (Last) Parsons

4. DATE OF DEATH (Month) (Day) (Year) Dec. 11 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH June 6, 1919

9. AGE (In years last birthday) 48 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 17

10b. KIND OF BUSINESS OR INDUSTRY Lumber

11. BIRTHPLACE (State or foreign country) Murray, Idaho

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Charles A. Parsons
BIRTHPLACE

14. MOTHER'S MAIDEN NAME Odille Lavernge
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) World War #2

16. SOCIAL SECURITY NO. 518-03-6870

17. INFORMANT'S OWN SIGNATURE Mrs. Barbara Parsons
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Lobar pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Uremia — months
DUE TO (c) Diabetes mellitus — yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Mar. 16, 19 59, *to* Dec. 11, 1967, *that I last saw the deceased alive on* Dec. 11, 1967, *and that death occurred at* 2:40 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [signature] M.D.

23b. ADDRESS Box 200 Wallace, Idaho

23c. DATE SIGNED 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 14, 1967

24c. NAME OF CEMETERY OR CREMATORY Restlawn Cemetery

24d. LOCATION (City, town, or county) Coeur D Alene (State) Idaho

DATE REC'D BY LOCAL REG. 12-18-67

REGISTRAR'S SIGNATURE [signature]

25. EMBALMER Derrell J. Juelfs

LICENSE NO. E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

DEC 20 1967
DEC 27 1967
JAN 5 1968
SEP 24 1970
OCT 26 1988

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5636
Local Reg. No. 81
Reg. Dist. No. 140

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

DEC 20 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Shoshone Co. Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 402
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Wallace
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) Martha
b. (Middle) Ann
c. (Last) Clark

4. DATE OF DEATH (Month) (Day) (Year) Dec. 11 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH June 27, 1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Millville, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Henry Hulse — BIRTHPLACE
14. MOTHER'S MAIDEN NAME Mary Jane Weaver — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-60-7602
17. INFORMANT'S OWN SIGNATURE X Martha A Clark — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH 2 mo

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Coronary Thrombosis — 4 mo
DUE TO (c) —

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. —

19a. DATE OF OPERATION —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) —
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) —
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) —

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? —

22. *I hereby certify that I attended the deceased from* Nov 22, 1966, *to* Dec 11, 1967, *that I last saw the deceased alive on* Dec 10, 1967, *and that death occurred at* 1 A *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 052 (Degree or title) Bonebrake MD
23b. ADDRESS 1 Kellogg Idaho
23c. DATE SIGNED 12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial 1
24b. DATE Dec. 13, 1967
24c. NAME OF CEMETERY OR CREMATORY Nine Mile Cemetery
24d. LOCATION (City, town, or county) Wallace (State) Idaho

DATE REC'D BY LOCAL REG. 12-16-67
REGISTRAR'S SIGNATURE [signature]
25. EMBALMER Derrell J. Juelfs
LICENSE NO. E-518

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Cornell's Ward Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

State File No. 5637
Local Reg. No.
Reg. Dist. No.

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
c. LENGTH OF STAY (in this place) 45 Minutes
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Bunker Hill Smelter 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 401 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) Kellogg, Idaho

3. NAME OF DECEASED (Type or Print)
a. (First) LOREN
b. (Middle) GEORGE
c. (Last) ROSS

4. DATE OF DEATH (Month) (Day) (Year) Dec. 13, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Dec. 20, 1905

9. AGE (In years last birthday) 61
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Shift Boss 07

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Campbell, Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Bert Ross
BIRTHPLACE Scotland

14. MOTHER'S MAIDEN NAME Eleanor Plough
BIRTHPLACE Minnesota

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. 469-03-5244

17. INFORMANT'S OWN SIGNATURE Robert G. Ross
ADDRESS Kellogg Ida.

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-13, 1967 *to* 12-13, 1967, *that I last saw the deceased alive on* 12-13, 1967, *and that death occurred at* About 9:39 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE T. M. Peterson, M.D.
(Degree or title)

23b. ADDRESS Wallace, Idaho

23c. DATE SIGNED 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 18 1967

24c. NAME OF CEMETERY OR CREMATORY Greenwood

24d. LOCATION (City, town, or county) Kellogg, Idaho (State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE Joe Devine

25. EMBALMER Donald Maisel

LICENSE NO. 452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5638
Local Reg. No. 83
Reg. Dist. No. 140

BIRTH NO.

RECEIVED JAN 2 1968 Bureau of Vital Statistics

STATE OF IDAHO

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township) Mullan
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home - Boulder Gulch 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Mullan
d. STREET ADDRESS (If rural, give location) Boulder Gulch

3. NAME OF DECEASED (Type or Print)
a. (First) Roy
b. (Middle) ---
c. (Last) Erickson

4. DATE OF DEATH (Month) (Day) (Year) Dec. 18, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH June 26, 1897

9. AGE (In years last birthday) 70
If UNDER 1 YEAR: Months / Days
If UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Shift Boss 07

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Butte, Montana

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE

14. MOTHER'S MAIDEN NAME BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-03-5194

17. INFORMANT'S OWN SIGNATURE Alvera Foster
ADDRESS Mullan, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 9744 Strangulation — INTERVAL BETWEEN ONSET AND DEATH: Few minutes

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify) Suicide?

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home, about

21c. (CITY, TOWN, OR TOWNSHIP) Mullan (COUNTY) 400 Shoshone (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) 12-18-67 about 3:45 p.m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR? Hung himself

22. *I hereby certify that I attended the deceased from* 12-18 *1967, to* 12-18 *, 1967, that I last saw the deceased alive on* 12-18 *, 1967, and that death occurred at about* 3:45 *a.m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) G. M. Peterson, M.D.

23b. ADDRESS Wallace, Idaho

23c. DATE SIGNED 12-20-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Cremation

24b. DATE Dec. 23, 1967

24c. NAME OF CEMETERY OR CREMATORY Smith & Co.

24d. LOCATION (City, town, or county) (State) Spokane, Wash.

DATE REC'D BY LOCAL REG. 12-22-67

REGISTRAR'S SIGNATURE

25. EMBALMER Derrell J. Juelfs

LICENSE NO. E-518

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

FEB 7 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 6 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JUL 17 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5639

Local Reg. No.

Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH

a. COUNTY 400 Shoshone — JAN 3 1968 — 400

b. CITY OR TOWN: Rural Shoshone County | LENGTH OF STAY (in this place): Minutes

d. FULL NAME OF HOSPITAL OR INSTITUTION: Enroute to Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho — b. COUNTY 400 Shoshone

c. CITY OR TOWN: Pinehurst

d. STREET ADDRESS (If rural, give location): 420 S. 2nd Street

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	Irvin	R.	Jackson	Dec.	24,	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months	Days	IF UNDER 24 HRS.: Hours	Min.
Male	White	Married 3	Nov. 28, 1912	55				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter 21	Carpentering	Wray, Colorado	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Harry Jackson	Nebraska	Mary E. Honeighaus	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	None 4301	523-01-8691	Catherine D. Jackson	Pinehurst, Ida

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Few seconds

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 12-24, 1962, *to* 12-24, 1967, *that I last saw the deceased alive on* 12-24, 1967, *and that death occurred at* 3:55 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. M. Peterson	M.D.	Wallace, Idaho	12-30-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 27, 1967	Shoshone Gardens	Pinehurst, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-2-68	Joe Devine	Donald Maisel	E 452

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Maisel Funeral Chapel

DUTIES: JAN 4 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5640
Local Reg. No. 84
Reg. Dist. No. 140

BIRTH NO.

RECEIVED
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 400 Shoshone
JAN 2 1968
000
b. CITY OR TOWN Crescent Mine
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 401
b. COUNTY Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) Sunshine Star Route

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
Robert	Clay	Ball	Dec. 26, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	August 27, 1936	31				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Miner 07	Mining	Wallace, Idaho	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Thomas Ball		Ellen Holbrook	

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-38-3091	X Mamie A Ball	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Fractured Skull, Fractured Neck — INTERVAL BETWEEN ONSET AND DEATH: few seconds

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Crushed face, left, Internal Injuries. Severe Compound Comminuted fracture of left femur. Severe penetrating wound left lower extremity from knee to into pelvis

DUE TO (c) Multiple Contusion Abrasions

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
	Laceration of Inner Left Thigh	YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
accident,	Mine	near Kellogg, Shoshone, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
12-26-67 about 6:45 p.m.	WHILE AT WORK ☒ NOT WHILE AT WORK ☐	Cave in (Mine)

22. *I hereby certify that I attended the deceased from* 12-26 1967, *to* 12-26, 1967, *that I last saw the deceased alive on* 12-26, 1967, *and that death occurred at* 6:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. M. Peterson	M.D.	Wallace, Idaho	12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 30, 1967	Greenwood Cemetery	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 30, 1967	Dale Cornell	Dale L. Cornell	E-406

FIRM NAME: Cornell's Ward Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 2 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 15 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5641
Local Reg. No.
Reg. Dist. No. 142

RECEIVED JAN 15 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 401 Shoshone 340
b. CITY OR TOWN Kellogg
c. LENGTH OF STAY (in this place) 10days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) West Shoshone Gen. Hosp. 141

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 401 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kellogg
d. STREET ADDRESS (If rural, give location) 15 East Market

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Raymond	S.	Boyd	Dec. 27, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	white	Married 3	Nov. 28, 1899	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Carpenter	Mining	Hansberg, Conn.	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Boyd	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No None	518-01-7927	Mary A Boyd	4201

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Left ventricular aneurysm

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO (b)~~

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Generalized arteriosclerosis & Arthritis, generalized, mixed type

INTERVAL BETWEEN ONSET AND DEATH
(a) about 14 years
(c) about 12 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 16 Sept, 1953, *to* 27 Dec, 1967, *that I last saw the deceased alive on* 27 December, 1967, *and that death occurred at* 2 16 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	105 (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Robert A. Cordwell,	M.D.	Kellogg Idaho	29 Dec 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 30, 1967	Greenwood	Kellogg, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
1-11-68	Joe Justice	Ronald Maisel	452

FIRM NAME: Maisel Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 22 1968 Bureau of Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5642
Local Reg. No. 4
Reg. Dist. No. 140

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 400 Shoshone 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) East Shoshone Hospital 138

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 400 Shoshone
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Silverton
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Richard b. (Middle) Lewis c. (Last) Hill

4. DATE OF DEATH (Month) (Day) (Year) Dec. 31, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Jan. 22, 1888

9. AGE (In years last birthday) 79 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner 07

10b. KIND OF BUSINESS OR INDUSTRY Mining

11. BIRTHPLACE (State or foreign country) Lancashire, England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Hill

14. MOTHER'S MAIDEN NAME Elinor Lewis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-14-3055

17. INFORMANT'S OWN SIGNATURE John F. Hill ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

5230

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 3 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Emphysema — 9 years
DUE TO (c) Silicosis — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Oct. 9, 1964, *to* Dec. 31, 1967, *that I last saw the deceased alive on* Dec. 31, 1967, *and that death occurred at* 7:25 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.

23b. ADDRESS Box 200 Wallace, Idaho

23c. DATE SIGNED 1-3-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Jan. 2, 1968

24c. NAME OF CEMETERY OR CREMATORY Nine Mile Cemetery

24d. LOCATION (City, town, or county) (State) Wallace, Idaho

DATE REC'D BY LOCAL REG. Jan. 18, 1968

REGISTRAR'S SIGNATURE

25. EMBALMER Derrell J. Juelfs

LICENSE NO. E-518

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Cornell's Ward Funeral Home

DUTIES:

JAN 2 ? 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 1 5 1992

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5643
Local Reg. No. D-420
Reg. Dist. No. 460

Certificate of Death

RECEIVED
STATE OF IDAHO

BIRTH NO.

DEC 7 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY 1 Week
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 743

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 225 5th St. North

3. NAME OF DECEASED (Type or Print)
a. (First) Rex
b. (Middle) Eugene
c. (Last) Deahl

4. DATE OF DEATH (Month) (Day) (Year) December 2,1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH March 10,1897
9. AGE (In years last birthday) 70 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Martinsville, Illinois
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME William Deahl — BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Mary Adams — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-42-6983A
17. INFORMANT'S OWN SIGNATURE Mrs R. E. Deahl — ADDRESS Twin Falls,

18. CAUSE OF DEATH 593X
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Uremia	7 days
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Renal failure	10 days
DUE TO (c)	Heart Failure	Years
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	Hepatic Failure	10 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1966, *to* Dec. 2, 1967, *that I last saw the deceased alive on* Dec. 2, 1967, *and that death occurred at* 6:20p *m., from the causes and on the date stated above.*

23a. SIGNATURE H. Thad Scholes M.D. 707 (Degree or title)
23b. ADDRESS 120 Adams, Twin Falls, Ida.
23c. DATE SIGNED 12-4-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec.6,1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-5-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER [signature]
LICENSE NO. 343

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: White Mortuary 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 14 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

State File No. 5644
Local Reg. No. D-938
Reg. Dist. No. 460

STATE OF IDAHO

BIRTH NO.

RECEIVED DEC 18 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 314
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 2 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 143 Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 211 7th Ave North

3. NAME OF DECEASED (Type or Print)
a. (First) JOSEPH
b. (Middle) D.
c. (Last) KALB

4. DATE OF DEATH (Month) December (Day) 2 (Year) 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	October 12, 1876	91				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) tailor 21
10b. KIND OF BUSINESS OR INDUSTRY tailor
11. BIRTHPLACE (State or foreign country) Perkionville, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Solomen Kalb — BIRTHPLACE Scotland
14. MOTHER'S MAIDEN NAME unknown — BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-28-4318
17. INFORMANT'S OWN SIGNATURE Richard J. Kalb — ADDRESS Alameda Calif

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) 157X Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH 2 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) C.A. pancreas
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Jan. 5, 1965, *to* Dec. 2, 1967, *that I last saw the deceased alive on* Dec 2, 1967, *and that death occurred at* 4.30 pm., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [illegible] MD
23b. ADDRESS 122 9th Ave No Buhl
23c. DATE SIGNED 12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Dec 5, 1967
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) Buhl (State) Idaho

DATE REC'D BY LOCAL REG. 12-15-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER George Farmer
LICENSE NO. E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Atherton-Dickard Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

SEP 11 1985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5645
Local Reg. No. D-739
Reg. Dist. No. 460

RECEIVED DEC 1 8 1967

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 102
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Bureau or Precinct) Buhl
c. LENGTH OF STAY (in this place) 2 yrs
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) Harral Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First) EDWARD b. (Middle) J. c. (Last) DRANEY

4. DATE OF DEATH (Month) December (Day) 3 (Year) 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) never married

8. DATE OF BIRTH July 23, 1885

9. AGE (In years last birthday) 82 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY agriculture

11. BIRTHPLACE (State or foreign country) Seneca, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Hugh Draney BIRTHPLACE Canada

14. MOTHER'S MAIDEN NAME Genevieve Boganshautz BIRTHPLACE Wisc

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 510-48-8675-j

17. INFORMANT'S OWN SIGNATURE Mary Draney ADDRESS Buhl

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Arteriosclerotic htt dis — INTERVAL BETWEEN ONSET AND DEATH: Years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalized atherosclerosis — 11
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Cystolapyelitis — days

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Sept 19, 1966, *to* Dec. 3, 1967, *that I last saw the deceased alive on* Dec. 2, 1967, *and that death occurred at* 10 30 p m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) MD

23b. ADDRESS 122 9th ave No. Buhl

23c. DATE SIGNED 12-5-67

24a. BURIAL, CREMATION, REMOVAL (Specify) removal 3

24b. DATE Dec 5, 1967

24c. NAME OF CEMETERY OR CREMATORY Seneca Cemetery

24d. LOCATION (City, town, or county) Seneca (State) Kansas

DATE REC'D BY LOCAL REG. 12-15-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER George Tanner LICENSE NO. E-480

FIRM NAME: Albertson-Dickaed Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES: JAN 3 1969

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

X

BIRTH NO.

Certificate of Death

RECEIVED Dec.

STATE OF IDAHO

State File No. 5646
Local Reg. No. D-423
Reg. Dist. No. 460

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls — DEC 1 5 1967 — 000
b. CITY OR TOWN Filer — Bureau of Vital Statistics — LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home 303 Main 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 — b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
d. STREET ADDRESS (If rural, give location) 303 Main

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	OLIVER	JAMES	WEATHERS	Dec. 5, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Married 3	June 24, 1878	89				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
22 Retired Shoe Repair	Store	Fayetteville, Missouri	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Unknown	Unknown	Unknown	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no	518-36-9208	Emma Weathers by	Filer, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary Occlusion	Minutes
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Arteriosclerotic heart dis	Years
DUE TO (c)	Generalized arteriosclerosis	Years
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* March 2, 1967, *to* March 3, 1967, *that I last saw the deceased alive on* March 3, 1967 *and that death occurred at* 9:00p m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. Rulling	MD	Buhl, Idaho	12.7.67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12.7.67	Filer IOOF Cem.	Filer, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-13-67	Pamela J. Johnson	Ronald J. Hamilton	E-470

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: White Mortuary Twin Falls, Idaho

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5647
Local Reg. No. D-937
Reg. Dist. No. 460

RECEIVED Dec 1 5 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 TWIN FALLS Bureau of Vital Statistics 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TWIN FALLS
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 718 Alturas Dr. 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 718 Alturas Dr.

3. NAME OF DECEASED (Type or Print): a. (First) THEODORE b. (Middle) RAYMOND c. (Last) LARSON

4. DATE OF DEATH (Month) (Day) (Year): December 5, 1967

5. SEX: Male

6. COLOR OR RACE: Caucasian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 28, 1906

9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.: 61

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant 22

10b. KIND OF BUSINESS OR INDUSTRY: Auto Supplies

11. BIRTHPLACE (State or foreign country): Marion, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Erick John Larson — BIRTHPLACE: Sweden

14. MOTHER'S MAIDEN NAME: Florence K. Samuelson — BIRTHPLACE: Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.: 518-38-2124

17. INFORMANT'S OWN SIGNATURE: X Mary Ellen Larson — ADDRESS: Twin Falls

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) INFARCTION OF MYOCARDIUM — INTERVAL BETWEEN ONSET AND DEATH: 11 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CORONARY THROMBOSIS — Jan. 1967
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-30-, 1967, *to* 12-5-, 1967, *that I last saw the deceased alive on* 12-4-, 1967, *and that death occurred at* 11:50 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE George E. Brown MD (Degree or title) 061

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 12-8-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 8, 1967

24c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG.: 12-13-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Edgar Robertson — LICENSE NO. E-509

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5648
Local Reg. No. D-339
Reg. Dist. No. 460

RECEIVED Dec NOV 15 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 303
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 2½ days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 211 Alexander

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	BRUCE	E.	NEWMAN	Dec. 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	Sept. 26, 1896	71				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
carpenter 11	construction	Oklahoma	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William F. Newman	Illinois	Vina Ann Wilson	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
yes	WW I 3	519-03-0012	Mrs Bruce Newman	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

543X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Tracheobronchitis with obstruction of air way with thick mucous. — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Gastritis with obstruction of pylorus — 1 month

DUE TO (c) Malnutrition due to (b) above

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. generalized arteriosclerosis — 10 to 20 yrs.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* 1/13, 19 67, *to* 12/6, 19 67, *that I last saw the deceased alive on* 12/5, 19 67, *and that death occurred at* 1:30a *m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vaughn McCord 422	MD	Twin Falls, Idaho	12/11/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
burial	12-9-67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-12-67	Pamela J. Johnson	Dale P. Patterson	E-451

FIRM NAME: TWIN FALLS MORTUARY

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 26 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5649
Local Reg. No. D-446
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 26 1967

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: 421 Twin Falls 000

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls

c. LENGTH OF STAY (in this place):

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Hazeldell Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 421

b. COUNTY: Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301

d. STREET ADDRESS (If rural, give location): 640 Filer Av. W.

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	NORA	L.	RAYL	December 6, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	Caucasian	Widowed 2	July 6, 1879	88				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
J. T. Shull	North Carolina	UNK	UNK

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service):

16. SOCIAL SECURITY NO. 518-44-1962A

17. INFORMANT'S OWN SIGNATURE: Mrs Olin Smith ADDRESS: Buhl, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

260X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Virus Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 week

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Diabetes Mellitus — 10 years

DUE TO (c) Generalized Arteriosclerosis — 15 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclorotic Heart Disease — 10 years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION: None

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 19 62, *to* December 5 19 67, *that I last saw the deceased alive on* Dec. 5, 19 67 *and that death occurred at* 3:25 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Vaughn McDonald 422 M.D.	1216 Filer Ave. E., Twin Falls	12/20/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 8, 1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-22-67	Pamela J. Johnson	[signature]	E-343

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: WHITE MORTAURY CHAPEL 733-6600

DEC 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5650
Local Reg. No. D-938
Reg. Dist. No. 460

REC Certificate of Death

Dec.

STATE OF IDAHO

BIRTH NO.

NOV 15 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 42 Twin Falls 088

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho b. COUNTY 248 Gooding

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Hagerman

d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First) Cleaom b. (Middle) c. (Last) Anderson

4. DATE OF DEATH (Month) Dec. (Day) 7, (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Aug. 4, 1913

9. AGE (In years last birthday) 54 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Home

11. BIRTHPLACE (State or foreign country) Presto, Idaho

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Wesley Glauner BIRTHPLACE Soda Springs, Ida.

14. MOTHER'S MAIDEN NAME Elsie Glauner BIRTHPLACE Camas Prairie, Ida.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None

16. SOCIAL SECURITY NO. None

17. INFORMANT'S OWN SIGNATURE D. F. Anderson ADDRESS Hagerman, Ida.

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Infarction of Myocardium — INTERVAL BETWEEN ONSET AND DEATH 6 Mo.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic coronary thrombosis

DUE TO (c) Mural thrombi of Heart

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Multiple Pulmonary emboli

Cardiac Cirrhosis

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Nov 4, 1967 *to* Dec 7, 1967, *that I last saw the deceased alive on* Dec 6, 1967, *and that death occurred at* 5:30 AM, *from the causes and on the date stated above.*

23a. SIGNATURE B. C. Kreisbaum M.D. 296 (Degree or title)

23b. ADDRESS 676 Shoup Twin Falls

23c. DATE SIGNED Dec 11 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 11, 1967

24c. NAME OF CEMETERY OR CREMATORY Hagerman Cemetery

24d. LOCATION (City, town, or county) Hagerman, (State) Idaho

DATE REC'D BY LOCAL REG. 12-12-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Eddie G. Leach

LICENSE NO. E-511

FIRM NAME: Thompson Chapel - Gooding, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63022

DUTIES:

DEC 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

FEB 13 1984

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5651
Local Reg. No. 270
Reg. Dist. No. 460

BIRTH NO. X

RECEIVED Dec. 1 51967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer 83328
d. STREET ADDRESS (If rural, give location) Route# 2

3. NAME OF DECEASED (Type or Print) a. (First) HELEN b. (Middle) W. c. (Last) BONNICHSEN

4. DATE OF DEATH (Month) (Day) (Year) December 7, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 5, 1918

9. AGE (In years last birthday) 49 | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Filer, Idaho

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Charles G. Williams BIRTHPLACE Nebraska

14. MOTHER'S MAIDEN NAME Minerva Page BIRTHPLACE Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-50-0439

17. INFORMANT'S OWN SIGNATURE Everett Bonnichsen ADDRESS Route 2 FILER, IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinoma of Left Breast — INTERVAL BETWEEN ONSET AND DEATH 12 mos.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) C Metastases to Lung,

DUE TO (c) locally + Bone

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 8-29-1961 *to* 12-7-1967, *that I last saw the deceased alive on* 12-7-1967, *and that death occurred at* 10:55 A.M. *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 518 M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 12.8.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12.9.67

24c. NAME OF CEMETERY OR CREMATORY Filer IOOF Cem.

24d. LOCATION (City, town, or county) Filer, Idaho (State)

DATE REC'D BY LOCAL REG. 12-13-67

REGISTRAR'S SIGNATURE Pamela Johnson

25. EMBALMER Ronald J. Hamilton LICENSE NO. E-470

FIRM NAME: White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 1 5 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

APR 2 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

JAN 9 1970

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

X

Certificate of Death

RECEIVED

STATE OF IDAHO

State File No. 5652
Local Reg. No. D-435
Reg. Dist. No. 460

BIRTH NO.

Dec. NOV 15 1967 000

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If outside place) Bureau of Vital Statistics
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 143 Magic Valley Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Murtaugh
d. STREET ADDRESS (If rural, give location) Route #1 83344

3. NAME OF DECEASED (Type or Print)
a. (First) Earl
b. (Middle) D.
c. (Last) Sears

4. DATE OF DEATH (Month) (Day) (Year) December 8, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov.15,1907
9. AGE (In years last birthday) 60 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mgr. Irrigation District 26
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Farmington, Utah
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Clarence Sears — BIRTHPLACE Salt Lake City, Utah
14. MOTHER'S MAIDEN NAME Maude Earl — BIRTHPLACE Salt Lake City, Utah

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 519-14-7485
17. INFORMANT'S OWN SIGNATURE Mrs Earl Sears — ADDRESS Murtaugh, Ida

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Metastatic Cancer of lung 6 months

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Carcinoma of Prostate 4 yrs

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

177X

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 15 Dec, 1950, *to* 8 Dec, 1967, *that I last saw the deceased alive on* 8 Dec, 1967, *and that death occurred at* 5 A. *m., from the causes and on the date stated above.*

23a. SIGNATURE Dean H Affleck 003 (Degree or title) MD
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 12.8.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12.11.67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park Cem.
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-13-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Russell D. Mikel
LICENSE NO. E-520

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: White Mortuary TwinFalls, Idaho

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 15 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED Certificate of Death

STATE OF IDAHO

State File No. 5653
Local Reg. No. D-437
Reg. Dist. No. 460

BIRTH NO. DEC 1 8 1967

1. PLACE OF DEATH
a. COUNTY 420 Bureau of Vital Statistics Twin Falls 101
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
c. LENGTH OF STAY (in this place) 8 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) HARRAL NURSING HOME 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 184 Buena Vista

3. NAME OF DECEASED (Type or Print)
a. (First) PERSIS
b. (Middle) ANN
c. (Last) DAY

4. DATE OF DEATH (Month) (Day) (Year) Dec. 8, 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Sept. 3, 1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Woodruff, Kansas
12. CITIZEN OF WHAT COUNTRY? m U.S.A.
13. FATHER'S NAME Julius E. Barnes — BIRTHPLACE New York
14. MOTHER'S MAIDEN NAME Silvina Vought — BIRTHPLACE Pennsylvania
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE SEE R Noel — ADDRESS 901 11th Ave. N. Buhl, Idaho 83316

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

493X

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Obesity, arteriosclerosis — Years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 9, 1967, *to* Dec 8, 1967, *that I last saw the deceased alive on* Dec 7, 1967, *and that death occurred at* 4:00 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE C W Cullings MD (Degree or title) 118
23b. ADDRESS 122 9th Ave No. Buhl Idaho
23c. DATE SIGNED 12-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/11/67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial
24d. LOCATION (City, town, or county) Twin Falls, (State) Idaho

DATE REC'D BY LOCAL REG. 12-15-67
REGISTRAR'S SIGNATURE Pamela J Johnson
25. EMBALMER George Farmer — LICENSE NO. E-480
FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DN-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED–CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

X

Certificate of Death

STATE OF IDAHO

State File No. 5654
Local Reg. No. D-433
Reg. Dist. No. 460

BIRTH NO.

RECEIVED Dec. NOV 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 400
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Skyview Manor 273

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS 869 Elm (If rural, give location) 83301

3. NAME OF DECEASED (Type or Print)
a. (First) JOHN
b. (Middle) W.
c. (Last) McDOWELL

4. DATE OF DEATH (Month) (Day) (Year) Dec. 8, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH Nov. 17, 1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming 04
10b. KIND OF BUSINESS OR INDUSTRY Farm ing
11. BIRTHPLACE (State or foreign country) Springerton, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Daniel McDowell
BIRTHPLACE Indiana
14. MOTHER'S MAIDEN NAME Julia Ann White
BIRTHPLACE Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. 518-36-6258A
17. INFORMANT'S OWN SIGNATURE X Phil D McDowell
ADDRESS TWIN FALLS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerosis — yrs
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 Feb, 1955, *to* 8 Dec, 1967, *that I last saw the deceased alive on* 8 Dec, 1967, *and that death occurred at* 1:45A *m., from the causes and on the date stated above.*

23a. SIGNATURE Dean H. Applechus 003 (Degree or title)
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED Dec. 11, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 12, 1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-13-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER Ronald J. Hamilton
LICENSE NO. E-470

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY Twin Falls, Ida. 733-6600

DEC 15 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5655
Local Reg. No. 0734
Reg. Dist. No. 460

BIRTH NO. X

RECEIVED Dec. 15 1967 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Twin Falls 421
b. CITY OR TOWN Twin Falls
c. LENGTH OF STAY (In this place) 92 years
d. FULL NAME OF HOSPITAL OR INSTITUTION HAZELDEL MANOR 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Twin Falls 421
c. CITY OR TOWN Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 251 Fifth Avenue East

3. NAME OF DECEASED (Type or Print): a. (First) CLEMENTINA b. (Middle) DRURY c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year): December 10, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): widowed 2

8. DATE OF BIRTH: December 25, 1875

9. AGE (In years last birthday): 91
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farming 04

10b. KIND OF BUSINESS OR INDUSTRY: agriculture

11. BIRTHPLACE (State or foreign country): Hustis Ford, Wisconsin

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Walter Drury
BIRTHPLACE: unknown

14. MOTHER'S MAIDEN NAME: Getty Whitcomb
BIRTHPLACE: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —0—

16. SOCIAL SECURITY NO. 518-31-9144

17. INFORMANT'S OWN SIGNATURE: Frances Muncey
ADDRESS: Pocatello, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c).

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4500

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Upper G I hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 12 hrs

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
(b) Severe generalized — 1 year
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Arteriosclerosis — 3 years

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-2, 1965, to 12-10, 1967, that I last saw the deceased alive on 12-10, 1967, and that death occurred at 12:00 Noon., from the causes and on the date stated above.

23a. SIGNATURE: C. Johnson 518 (Degree or title) M.D.

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: Dec. 13, 1967

24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State): Twin Falls Idaho

DATE REC'D BY LOCAL REG.: 12-13-67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: Donald J. Hamilton

LICENSE NO. E-470

FIRM NAME: WHITE MORTUARY 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

X

Certificate of Death

STATE OF IDAHO

State File No. 5656
Local Reg. No. D-436
Reg. Dist. No. 460

RECEIVED
DEC 15 1967
BUREAU OF VITAL STATISTICS

BIRTH NO. Dec.

1. PLACE OF DEATH
a. COUNTY 427 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY IN (this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl, 83316
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
William	K.	Potts	December 11, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	April 5, 1902	65				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Insurance Agent 24	Insurance	Ogden, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
William Potts	Netherlands	Lena	unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	519-09-7034A	[signature]	Twin Falls, Id

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

490X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) pneumonia labar — INTERVAL BETWEEN ONSET AND DEATH: 1 wks.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Cachexia generally. 3 yrs.

DUE TO (c) stricture Oesophagus. 5 yrs.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 12-7, 1967, *to* 12-11, 1967, *that I last saw the deceased alive on* 12-10, 1967, *and that death occurred at* 12:25a m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Harry F. Brumbach jr MD 064	676 Shoup W.	12-11-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Removal 3	Dec. 13, 1967	Ogden City Cemetery	Ogden, Weber, Utah

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-13-67	Pamela J. Johnson	Ronald D. Hamilton	E-470

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: FEB 14 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5657
Local Reg. No. D-446
Reg. Dist. No. 460

RECEIVED DEC 18 1967

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 47 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 5 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 212 4th Ave. E. 83301

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 05 California
b. COUNTY 555 San Mateo
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Redwood City, California 94061
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	LOIS	ARLENE	HOUK	Dec. 12, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Divorced 4	Feb. 1, 1927	40				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Pocatello, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME L. A. Watts — BIRTHPLACE Unknown
14. MOTHER'S MAIDEN NAME Unknown — BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ———
16. SOCIAL SECURITY NO. 519-24-0093
17. INFORMANT'S OWN SIGNATURE Mrs Homer Houk — ADDRESS TWIN FALLS IDAHO

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Asphyxiation — INTERVAL BETWEEN ONSET AND DEATH: Unknown

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Aspiration of food particles — Unknown
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chronic Alcoholism

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Investigation Only, *that I last saw the deceased alive on* ———, *and that death occurred at* ——— m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
H. Thad Schober M.D.	T.F. County Coroner	120 Adams, Twin Falls, Ida.	12-14-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial-Removal	12/13/67		Pocatello, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-15-67	Pamela J. Johnson	Jerry L. Holman	E-516

FIRM NAME: WHITE MORTUARY

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information. DEC 27 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5658
Local Reg. No. D-442
Reg. Dist. No. 460

BIRTH NO.

DEC 26 1967

Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 427 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 13 Idaho
b. COUNTY 420 T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly 83341
d. STREET ADDRESS (If rural, give location) 229 East Madison

3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) W. c. (Last) KOCH

4. DATE OF DEATH (Month) (Day) (Year) December 13, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH October 1, 1905
9. AGE (In years last birthday) 62 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Service Station Op. 06
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME David Koch BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME unknown BIRTHPLACE unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 506-01-0935
17. INFORMANT'S OWN SIGNATURE Mrs. Henry Koch, ADDRESS Kimberly, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH Undetermined

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart — unknown
DUE TO (c) Disease

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Hyperuricemia

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5-19, 1964, *to* 12/13/, 1967, *that I last saw the deceased alive on* 12-11, 1967, *and that death occurred at* 9:30 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 12-16-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/18/67
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-18-67
REGISTRAR'S SIGNATURE Pamela J. Johnson
25. EMBALMER James C. Reynolds
LICENSE NO. E-279
FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

JAN 3 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

OCT 16 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED
DEC 19 1967
Bureau of Vital Statistics

State File No. 5659
Local Reg. No. D 444
Reg. Dist. No. 460

Certificate of Death

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE 420 Idaho
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 1701 Poplar Street

3. NAME OF DECEASED (Type or Print)
a. (First) JEROME
b. (Middle) T.
c. (Last) O'CONNOR

4. DATE OF DEATH (Month) (Day) (Year) Dec. 13, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Never Married

8. DATE OF BIRTH Aug. 10, 1914

9. AGE (In years last birthday) 53
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Priest, Roman Catholic Church

10b. KIND OF BUSINESS OR INDUSTRY 18

11. BIRTHPLACE (State or foreign country) County Cork, Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Jerome O'Connor
BIRTHPLACE Ireland

14. MOTHER'S MAIDEN NAME Hannah Toomey
BIRTHPLACE Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Timothy Connor
ADDRESS 11126 Louisville Detroit

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion
INTERVAL BETWEEN ONSET AND DEATH: Minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease
INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 18, 1964 *to* Dec. 13, 1967, *that I last saw the deceased alive on* Dec. 11, 1967, *and that death occurred at* 7:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS 1229 4th Ave No Twin Falls

23c. DATE SIGNED 12-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Removal

24b. DATE 12/21/67

24c. NAME OF CEMETERY OR CREMATORY Kanturk

24d. LOCATION (City, town, or county) (State) County Cork, Ireland

DATE REC'D BY LOCAL REG. 12-16-67

REGISTRAR'S SIGNATURE Pamela Johnson

25. EMBALMER Robert A. Dickard

LICENSE NO. E-312

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form OH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 20 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5660
Local Reg. No. D-443
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 26 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY: Twin Falls 421
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (In this place): 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE: Idaho 421
b. COUNTY: T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls 83301
d. STREET ADDRESS (If rural, give location): 236 6th Avenue East

3. NAME OF DECEASED (Type or Print): a. (First) EDWIN b. (Middle) R. c. (Last) BUSS

4. DATE OF DEATH (Month) (Day) (Year): December 13, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married 3

8. DATE OF BIRTH: March 29, 1907

9. AGE (In years last birthday): 60 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Construction Worker 11

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Hoskins, Nebraska

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Fred Buss — BIRTHPLACE: Nebraska

14. MOTHER'S MAIDEN NAME: Alvina Zastrow — BIRTHPLACE: Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 712-05-4200

17. INFORMANT'S OWN SIGNATURE: Mildred Buss, Twin Falls, ADDRESS Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cardiac Arrest — INTERVAL BETWEEN ONSET AND DEATH:

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): Myocardial Infarction

DUE TO (c): Coronary Artery Disease

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from* Investigation Only, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* 5:25 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE: J. Thad Selchau M.D. 583 (Degree or title) TF County Coroner

23b. ADDRESS: Twin Falls, Idaho

23c. DATE SIGNED: 12-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-18-1967

24c. NAME OF CEMETERY OR CREMATORY: Sunset Mem. Park

24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 12/18/67

REGISTRAR'S SIGNATURE: Pamela J. Johnson

25. EMBALMER: James C. Reynolds — LICENSE NO.: E-279

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

DEC 2 7 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

DEC 28 1967

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 4 1968

APR 25 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5661
Local Reg. No. P-447
Reg. Dist. No. 460

RECEIVED
DEC 26 1967
Bureau of Vital Statistics

BIRTH NO. 000

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) 743
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 421 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
d. STREET ADDRESS (If rural, give location) 304 Sunnyview Court

3. NAME OF DECEASED (Type or Print)
a. (First) ALBERT
b. (Middle) D.
c. (Last) HUNTLEY

4. DATE OF DEATH (Month) (Day) (Year) 12-14-1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH 11-26-1876

9. AGE (In years last birthday) 91
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Black Hawk City, Iowa

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Charles E. Huntley
BIRTHPLACE Unknown

14. MOTHER'S MAIDEN NAME Mary Smith
BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-09-7218BT

17. INFORMANT'S OWN SIGNATURE Mrs Sadie Huntley ADDRESS 304 Sunnyview Court Twin Falls

4201

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 year

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic cardio-
DUE TO (c) Vascular disease — 30 years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-1-67, 19__, *to* 12-14-67, 19__, *that I last saw the deceased alive on* 12-14-67, 19__, *and that death occurred at* 1:00 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE Harrold L Sloat 508 (Degree or title) M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 12-15-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-19-1967

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-18-67

REGISTRAR'S SIGNATURE Pamela F. Johnson

25. EMBALMER Paul D. Reynolds Paul D. Reynolds

LICENSE NO. E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5662
Local Reg. No. D-247
Reg. Dist. No. 420

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls — DEC 26 1967 — 102
b. CITY OR TOWN Buhl — Bureau of Vital Statistics — STAY (in this place) 2 yrs.
d. FULL NAME OF HOSPITAL OR INSTITUTION Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 — b. COUNTY Twin Falls
c. CITY OR TOWN Buhl
d. STREET ADDRESS (If rural, give location) 412 13th Ave. North

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	Lena	I.	Diehl	Dec. 16, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White	Married 3	Sept. 12, 1879	88		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
House wife 01	Own home	McComb, Illinois	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
John Savage	Illinois	Ella Scudder	Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No	518-26-4019	M. R. Diehl	442 Walnut T.F. Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Generalyzed Arteriosclerosis — years
DUE TO (c) Arteriosclerotic Heart Disease — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* Oct 13, 1967, *to* Dec. 16, 1967, *that I last saw the deceased alive on* Dec 16, 1967 *and that death occurred at* 5:30 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. McCullagh MD	122 9th Ave No Buhl	12-18-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 18, 1967	Buhl, Cemetery	Buhl Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-21-67	Pamela Johnson	Jim A. Hopkins	E-482

Federal Security Agency
United States Public Health Service
Form DH-[illegible]21

FIRM NAME: Buhl Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 216.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5663
Local Reg. No. P-499
Reg. Dist. No. 460

RECEIVED DEC 26 1967 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 202
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
LENGTH OF STAY (in this place) 2 Months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Harral Nursing Home 205

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 929 Burley Avenue

3. NAME OF DECEASED (Type or Print) a. (First) ROSE b. (Middle) L. c. (Last) JAROLIMEK

4. DATE OF DEATH (Month) (Day) (Year) Dec. 18, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 5, 1909

9. AGE (In years last birthday) 58 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Comstock, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME J. H. Weverka BIRTHPLACE Nebraska

14. MOTHER'S MAIDEN NAME Pauline Moraviac BIRTHPLACE Nebraska

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No

16. SOCIAL SECURITY NO. 506-30-6087

17. INFORMANT'S OWN SIGNATURE Ollie Jarolimek ADDRESS 929 Burley Ave. Buhl, Ida.

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastasis from Ca of Lft Breast 2 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 4, 1964, *to* Dec. 18, 1967, *that I last saw the deceased alive on* Dec. 18, 1967, *and that death occurred at* 2:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 118 (Degree or title)

23b. ADDRESS R2 9th Ave No Buhl

23c. DATE SIGNED 12/19/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12/21/67

24c. NAME OF CEMETERY OR CREMATORY Buhl

24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. 12-22-67

REGISTRAR'S SIGNATURE Pamela L. Johnson

25. EMBALMER George Forner LICENSE NO. E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5664
Local Reg. No. D-448
Reg. Dist. No. 460

BIRTH NO.

RECEIVED DEC 26 1967 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY 42/ Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (In this place) 12 hours
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls 402
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly
d. STREET ADDRESS (If rural, give location) 308 West Taylore

3. NAME OF DECEASED (Type or Print) a. (First) LENA b. (Middle) AUDREY c. (Last) PROCTOR

4. DATE OF DEATH (Month) (Day) (Year) December 18, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH March 7, 1891

9. AGE (In years last birthday) 76 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker 01

10b. KIND OF BUSINESS OR INDUSTRY Own home

11. BIRTHPLACE (State or foreign country) Green Forest, Arkansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME William Timothy Bailey, BIRTHPLACE Kentucky

14. MOTHER'S MAIDEN NAME Martha Jane Tabor, BIRTHPLACE Arkansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518-14-2199

17. INFORMANT'S OWN SIGNATURE X R. S. Proctor ADDRESS Kimberly, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Acute Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 45 Min.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Diabetic Acidosis — 12 hrs.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

260X

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1954, *to* Dec 18, 1967, *that I last saw the deceased alive on* Dec 18, 1967, *and that death occurred at* 7:10p. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 286 O. Ellis Knight M.D.

23b. ADDRESS Kimberly, Idaho

23c. DATE SIGNED 12/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12-21-67

24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12/21/67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER William R. Boyd

LICENSE NO. E-490

FIRM NAME: Twin Falls Mortuary

Federal Security Agency
United States Public Health Service

Form DH-63021

DEC 27 1967

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

X

Certificate of Death

RECEIVED
JAN 2 1968
Bureau of Vital Statistics

STATE OF IDAHO

State File No. 5665
Local Reg. No. D-454
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 146
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Kimberly
STAY (in this place) 46 years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Home (½ mi. N. of Kimberly) 800

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural - Kimberly 83341
d. STREET ADDRESS (If rural, give location) ½ mi. N. of Kimberly Rt#1

3. NAME OF DECEASED (Type or Print)
a. (First) WALTER
b. (Middle) ---
c. (Last) NORRIS

4. DATE OF DEATH (Month) (Day) (Year) December 20,1967

5. SEX male
6. COLOR OR RACE white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH March 29,1890
9. AGE (In years last birthday) 77 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer 04
10b. KIND OF BUSINESS OR INDUSTRY agriculture
11. BIRTHPLACE (State or foreign country) Ohio
12. CITIZEN OF WHAT COUNTRY? Usa

13. FATHER'S NAME John H. Norris — BIRTHPLACE Ohio
14. MOTHER'S MAIDEN NAME Rebecca Barrett — BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) -0-
16. SOCIAL SECURITY NO. 519-28-0247 A
17. INFORMANT'S OWN SIGNATURE X Mrs Walter Norris — ADDRESS Kimberly, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

260X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Diabetes Mellitus — INTERVAL BETWEEN ONSET AND DEATH 6 months

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
~~DUE TO~~ (b) Carcinoma of Prostate — 1 month
~~DUE TO~~ (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death Generalized Arteriosclerosis with Right hemiparesis & Motor aphasia — 10 years

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-11-, 1957, *to* 12-20, 1967, *that I last saw the deceased alive on* 12-11, 1967, *and that death occurred at* 9:00 P m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 578 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho 83301
23c. DATE SIGNED 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify) burial
24b. DATE Dec.26,1967
24c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-29-67
REGISTRAR'S SIGNATURE Vera Ryals
25. EMBALMER Ronald J. Hamilton
LICENSE NO. E-470

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WHITE MORTUARY 733-6600

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5666
Local Reg. No. D-458
Reg. Dist. No. 460

BIRTH NO.

JAN 2 1968

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 421 Twin Falls 306

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

c. LENGTH OF STAY (in this place) 1 Day

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 743

USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 420

b. COUNTY Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl

d. STREET ADDRESS (If rural, give location) 425 North Broadway

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	MARGERY	F.	LEWTON	Dec. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Widowed 2	Sept. 25, 1899	68				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own Home	Dingle, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Alfred Sparks	Unknown	Sarah Jane Grimett	Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
		Corey D. Lewton	1823 Cleveland Caldwell, Ida.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Coronary occlusion	Hours
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Hypertensive heart dis.	Year
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Diabetes mellitus	Year

4201

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 9-20, 1961, *to* 12-20, 1967, *that I last saw the deceased alive on* 12-20, 1967, *and that death occurred at* 5:45 p. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
C. C. Cullings	M.D.	Buhl Idaho	12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/26/67	Buhl	Buhl, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-29-67	Vera Ryals	George Tanner	E-480

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 20 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

X

Certificate of Death

STATE OF IDAHO

State File No. 5667
Local Reg. No. D-455
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JAN 2 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Route # 3
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) DOA Magic Valley Memorial 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Rural Route # 3 83301
d. STREET ADDRESS (If rural, give location) Twin Falls

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
JAMES	ERNEST	ALLRED	Dec. 20, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married 3	April 10, 1898	69				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
farmer 04	farming	Richfield, Utah	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
James Ernest Allred	Utah	Hattie Jensen	Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no -----	518-14-3539	Ernest Allred Jr.	R#3 Twin Falls

4201

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) CORONARY OCCLUSION — INTERVAL BETWEEN ONSET AND DEATH: MINUTES

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) ARTERIOSCLEROSIS
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 10/26/67 *to* 12/20, 1967, *that I last saw the deceased alive on* 12/20 (DOA) 1967, *and that death occurred at* 11:00 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
V. V. Telford	525 MD-1	153 Blue Lakes Blvd North, Twin Fa.	12/21/67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec. 23, 1967	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-29-67	Vera Ryals	Jerry D. Holman	E-516

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 23 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5668
Local Reg. No. D-453
Reg. Dist. No. 460

Certificate of Death

RECEIVED
JAN 2 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (If not in hospital or institution, give street address or location)
d. FULL NAME OF HOSPITAL OR INSTITUTION Hazeldel Manor 285

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY T.Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) JOHANNA
b. (Middle)
c. (Last) DIERKER

4. DATE OF DEATH (Month) (Day) (Year) December 21,1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH July 7, 1888
9. AGE (In years last birthday) 79 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Hamel, Illinois
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Henry Bentrup — BIRTHPLACE Germany
14. MOTHER'S MAIDEN NAME Sophia Doeding — BIRTHPLACE Worden, Illinois

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 519-40-6962-D
17. INFORMANT'S OWN SIGNATURE Jerome Adeline Aufderheide — ADDRESS Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Broncho pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.
Generalized arteriosclerosis — 10 yr +
Arteriosclerotic Heart Disease — 10 yr +

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 5 Mont, 19 63, *to* 12/21/, 19 67, *that I last saw the deceased alive on* 20 Dec, 19 67, *and that death occurred at* 7:15p. m., *from the causes and on the date stated above.*

23a. SIGNATURE James H. Spafford 489 (Degree or title) M.D.
23b. ADDRESS Twin Falls, Idaho
23c. DATE SIGNED 12/22/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/27/67
24c. NAME OF CEMETERY OR CREMATORY Clover Cemetery
24d. LOCATION (City, town, or county) (State) S.E. of Buhl, Idaho

DATE REC'D BY LOCAL REG. 12-28-67
REGISTRAR'S SIGNATURE Vera Ryals
25. EMBALMER Paul D. Reynolds — LICENSE NO. E-495

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Reynolds Funeral Chapel

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 3 1969

JUL 11 1975

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5669
Local Reg. No. D-450
Reg. Dist. No. 460

BIRTH NO.

DEC 26 1967

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 421 Twin Falls 158

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

c. LENGTH OF STAY (in this place) 58 yrs.

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 811 East Main Avenue 002

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 421 b. COUNTY Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls

d. STREET ADDRESS (If rural, give location) 811 East Main Avenue

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ANDREW	BASCOM	WIDENER	December 21, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	Widowed 2	April 19, 1877	90				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Carpenter 16

10b. KIND OF BUSINESS OR INDUSTRY Construction

11. BIRTHPLACE (State or foreign country) Damascus, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME BIRTHPLACE William Widener, Virginia

14. MOTHER'S MAIDEN NAME BIRTHPLACE Ellen Edmondson, North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) - - - - - - -

16. SOCIAL SECURITY NO. 518-60-8447

17. INFORMANT'S OWN SIGNATURE Wanda Widener ADDRESS Twin Falls, Ida

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

4200

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH 5m

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart

DUE TO (c) Ulcers — 10 Years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-4, 1960, *to* 12-21, 1967, *that I last saw the deceased alive on* 12-5, 1967, *and that death occurred at* 5:00 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 578 — 23b. ADDRESS Twin Falls, Idaho 83301 — 23c. DATE SIGNED 12-21-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12-23-67	Sunset Memorial Park	Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-22-67

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER William J. Boyd — LICENSE NO. E-490

FIRM NAME: Twin Falls Mortuary

Federal Security Agency
United States Public Health Service

Form DH-65021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 27 1967

MAY 25 1984

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5670
Local Reg. No. D-459
Reg. Dist. No. 460

BIRTH NO.

RECEIVED JAN 2 1968 VITAL STATISTICS

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 307
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in local Statistic) 1 Day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 401 East Main Street

3. NAME OF DECEASED (Type or Print) a. (First) HENRY b. (Middle) W. c. (Last) LEHMAN

4. DATE OF DEATH (Month) (Day) (Year) Dec. 24, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH Aug. 9, 1890

9. AGE (In years last birthday) 77 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Agriculture

11. BIRTHPLACE (State or foreign country) Eustis, Nebraska

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Frank O. Lehman
BIRTHPLACE Iowa

14. MOTHER'S MAIDEN NAME Mary Johnson
BIRTHPLACE Indiana

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes—Mexican Border 1916 2

16. SOCIAL SECURITY NO. 518-42-0869

17. INFORMANT'S OWN SIGNATURE RT #2 Wendell, Idaho ADDRESS

4281

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — year
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* March 3, 1963, *to* Dec. 24, 1967, *that I last saw the deceased alive on* Dec. 24, 1967, *and that death occurred at* 12:40 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) MD

23b. ADDRESS 122 9th Ave No Buhl

23c. DATE SIGNED 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12/28/67

24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery

24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. 12-29-67

REGISTRAR'S SIGNATURE Vera Ryals

25. EMBALMER Robert F. Dickard

LICENSE NO. E-312

FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 12 1968

NOV 2 1972

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

RECEIVED JAN 2 1968 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 5671
Local Reg. No. D-457
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF [illegible] (If outside place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420
b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Filer, Idaho 83328
d. STREET ADDRESS (If rural, give location) Rural Route # 2

3. NAME OF DECEASED (Type or Print)
a. (First) FRED
b. (Middle) W.
c. (Last) HAMAN

4. DATE OF DEATH (Month) (Day) (Year) Dec. 24, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married 3
8. DATE OF BIRTH Oct. 27, 1892
9. AGE (In years last birthday) 75 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04
10b. KIND OF BUSINESS OR INDUSTRY Farming
11. BIRTHPLACE (State or foreign country) Harlen, Iowa
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Haman — BIRTHPLACE Manning, Iowa
14. MOTHER'S MAIDEN NAME Emma Law — BIRTHPLACE Germany

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service) -------
16. SOCIAL SECURITY NO. 518-03-9948A
17. INFORMANT'S OWN SIGNATURE Laura Haman — ADDRESS Filer, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

443X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: Days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Arteriosclerotic Heart Disease — years
DUE TO (c) Hypertensive Heart Disease — years

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 22, 1967 *to* Dec 24, 1967, *that I last saw the deceased alive on* Dec 24, 1967, *and that death occurred at* 11:00 am *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] (Degree or title) 18
23b. ADDRESS 1229 4th Ave No Bull
23c. DATE SIGNED 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec. 28, 1967
24c. NAME OF CEMETERY OR CREMATORY Filer IOOF Cemetery
24d. LOCATION (City, town, or county) (State) Filer, Idaho

DATE REC'D BY LOCAL REG. 12-27-67
REGISTRAR'S SIGNATURE V. Ryals
25. EMBALMER Jerry D. Holman — LICENSE NO. E-516

Federal Security Agency
United States Public Health Service
Form BH-63021

FIRM NAME: White Mortuary

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

RECEIVED

JAN 2 1968

Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5672
Local Reg. No. D-460
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 000 Magic Valley Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Buhl
d. STREET ADDRESS (If rural, give location) 516 North Broadway

3. NAME OF DECEASED (Type or Print) a. (First) JOHN b. (Middle) L. c. (Last) MC MANAMAN

4. DATE OF DEATH (Month) (Day) (Year) Dec. 24, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Sept. 14, 1894
9. AGE (In years last birthday) 73 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant 22
10b. KIND OF BUSINESS OR INDUSTRY Retail
11. BIRTHPLACE (State or foreign country) Lincoln, Nebraska
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John McManaman BIRTHPLACE Ireland
14. MOTHER'S MAIDEN NAME Ann McNamara BIRTHPLACE Ireland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 518-36-9166
17. INFORMANT'S OWN SIGNATURE Robert McManaman ADDRESS 115 8th N. Buhl, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4201

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH minutes

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) arterio sclerotic hrt dis — year

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June 6, 1964, *to* Dec. 24, 1967, *that I last saw the deceased alive on* Dec. 23, 1967, *and that death occurred at* 10:45 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE C W Cullings 118 (Degree or title)
23b. ADDRESS 122 9th Ave No Buhl
23c. DATE SIGNED 12-26-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE 12/28/67
24c. NAME OF CEMETERY OR CREMATORY Buhl Cemetery
24d. LOCATION (City, town, or county) (State) Buhl, Idaho

DATE REC'D BY LOCAL REG. 12-29-67
REGISTRAR'S SIGNATURE Veva Ryals
25. EMBALMER George Farmer
LICENSE NO. E-480

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME ALBERTSON-DICKARD FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES: JUN 19 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5673
Local Reg. No. D-456
Reg. Dist. No. 460

Certificate of Death

RECEIVED

STATE OF IDAHO

BIRTH NO.

JAN 2 1968

Bureau of Vital Statistics

1. PLACE OF DEATH

a. COUNTY 421 Twin Falls

b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301

c. LENGTH OF STAY (in this place)

d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Memorial Hosp. 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho 421

b. COUNTY Twin Falls

c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301

d. STREET ADDRESS (If rural, give location) 343 2nd Ave. North

3. NAME OF DECEASED (Type or Print)

a. (First) Roy

b. (Middle)

c. (Last) Martin

4. DATE OF DEATH (Month) (Day) (Year) December 26, 1967

5. SEX Male

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Divorced 4

8. DATE OF BIRTH Oct. 19, 1893

9. AGE (In years last birthday) 74 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 04

10b. KIND OF BUSINESS OR INDUSTRY Retired Farmer

11. BIRTHPLACE (State or foreign country) Southwest City, Missouri

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Joseph Martin — BIRTHPLACE

14. MOTHER'S MAIDEN NAME Susan Martin — BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 499-10-7770A

17. INFORMANT'S OWN SIGNATURE Twin Falls, Ida. — ADDRESS

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

332X

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	—	—
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	—	—
DUE TO (c)	Cerebral thrombosis	1 day
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*	—	

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* April 25, 1960, *to* Dec. 26, 1967, *that I last saw the deceased alive on* Dec. 26, 1967 *and that death occurred at* 8:15a *m., from the causes and on the date stated above.*

23a. SIGNATURE Willard H. Clark 092 (Degree or title) MD

23b. ADDRESS 632 Main Ave N. T.F.

23c. DATE SIGNED 12/26/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 29, 1967

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. 12-29-67

REGISTRAR'S SIGNATURE O. Ryals

25. EMBALMER Edgar Robertson

LICENSE NO. E-507

FIRM NAME: White Mortuary 733-6600

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to [illegible] the facts shall sign HIS name in addition to giving the source of information.

JUN 12 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5674
Local Reg. No. D-451
Reg. Dist. No. 460

RECEIVED JAN 2 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
c. LENGTH OF STAY (in this place) DOA
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 421 T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls
d. STREET ADDRESS (If rural, give location) 1755 Falls Avenue East

3. NAME OF DECEASED (Type or Print) a. (First) CARMEN b. (Middle) DARLENE c. (Last) BJORNN

4. DATE OF DEATH (Month) (Day) (Year) December 26, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH June 19, 1924

9. AGE (In years last birthday) 43
IF UNDER 1 YEAR Months / Days
IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Sabetha, Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Lee Sorrell
BIRTHPLACE Kentucky

14. MOTHER'S MAIDEN NAME Helen McDonald
BIRTHPLACE Sabetha, Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 539-20-0888

17. INFORMANT'S OWN SIGNATURE Gordon L. Bjornn, ADDRESS Twin Falls, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

1620

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) CARCINOMA OF UTERUS — INTERVAL BETWEEN ONSET AND DEATH 9 mo.

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 10-6, 1952, *to* 12/26, 1967, *that I last saw the deceased alive on* 12-25, 1967, *and that death occurred at* 5:55 a. m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) 525 M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 12-27-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12/29/67

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho

DATE REC'D BY LOCAL REG. 12-28-67

REGISTRAR'S SIGNATURE Vera Ryals

25. EMBALMER Paul D. Reynolds

LICENSE NO. E-495

FIRM NAME: Reynolds Funeral Chapel

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

JAN 2 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5675
Local Reg. No. D-452
Reg. Dist. No. 460

Certificate of Death

RECEIVED
JAN 2 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Murtaugh (rural)
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Route # 1 83344 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 420 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Murtaugh (rural)
d. STREET ADDRESS (If rural, give location) Route # 1 83344

3. NAME OF DECEASED (Type or Print)
a. (First) Mary b. (Middle) Elizabeth c. (Last) Glenn

4. DATE OF DEATH (Month) (Day) (Year) December 27,1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH January 7,1880
9. AGE (In years last birthday) 87 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY home
11. BIRTHPLACE (State or foreign country) Toole, Utah
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Cyrus Tolman BIRTHPLACE unknown
14. MOTHER'S MAIDEN NAME Louise Pickett BIRTHPLACE Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Elzina J. Jensen ADDRESS Murtaugh, Idaho

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Right heart failure	10 minutes
ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Chronic myocarditis	10 Years
DUE TO (c)	Arteriosclerotic heart disease	15 Years
II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*		

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19 45, *to* _____, 19 67, *that I last saw the deceased alive on* June, 19 67, *and that death occurred at* 11:00a *m., from the causes and on the date stated above.*

23a. SIGNATURE [signature] 246 (Degree or title) Glenn A. Hoss, M.D.
23b. ADDRESS 1221 Lynwood Mall Twin Falls, Idaho
23c. DATE SIGNED 12-28-67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec.30,1967
24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. 12-29-67
REGISTRAR'S SIGNATURE Vera Ryals
25. EMBALMER Ronald J. Hamilton
LICENSE NO. E-470

Federal Security Agency
United States Public Health Service
Form DH-69021
FIRM NAME: White Mortuary 733-6 000

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 5 1980

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

NOV 15 1999

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5676
Local Reg. No. D-463
Reg. Dist. No. 460

RECEIVED JAN 12 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 420 Twin Falls
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly 83341
c. LENGTH OF STAY (in this place) 000
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Mt. View Nursing Home 297

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission).
a. STATE Idaho
b. COUNTY 420 Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Kimberly 83341
d. STREET ADDRESS (If rural, give location) Mt. View Nursing Home

3. NAME OF DECEASED (Type or Print) a. (First) IDA b. (Middle) MAY c. (Last) SMITH

4. DATE OF DEATH (Month) (Day) (Year) Dec. 28, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widow 2

8. DATE OF BIRTH Dec. 2, 1873

9. AGE (In years last birthday) 94 | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Idaho City, Idaho

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME William Barley BIRTHPLACE Kentucky

14. MOTHER'S MAIDEN NAME Americana BIRTHPLACE Ohio

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ----

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE *Helen P Babcock ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

490X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Pneumonia - lobar — INTERVAL BETWEEN ONSET AND DEATH: 4 days

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* June, 1967, *to* Dec. 28, 1967, *that I last saw the deceased alive on* Dec. 28, 1967, *and that death occurred at* 3:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE O. Ellis Knight 286 (Degree or title) MD

23b. ADDRESS Kimberly, Idaho

23c. DATE SIGNED 12.29.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12.30.67

24c. NAME OF CEMETERY OR CREMATORY Morris Hill Cem.

24d. LOCATION (City, town, or county) Boise, Idaho (State)

DATE REC'D BY LOCAL REG. 1/10/68

REGISTRAR'S SIGNATURE Pamela P Johnson

25. EMBALMER

LICENSE NO. 343

FIRM NAME White Mortuary Twin Falls, Idaho

Federal Security Agency
United States Public Health Service

Form PH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 18 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

AUG 22 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under Items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (Items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 4 1968 Bureau of Vital Statistics

State File No. 5677
Local Reg. No. D-463
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Twin Falls 83301
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Twin Falls Clinic Hosp. 144

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 421 b. COUNTY Twin Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TwinFalls 83301
d. STREET ADDRESS (If rural, give location) 712 Blue Lakes Blvd

3. NAME OF DECEASED (Type or Print) a. (First) BESSIE b. (Middle) E. c. (Last) TURNIPSEED

4. DATE OF DEATH (Month) (Day) (Year) December 28,1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH August 27,1889

9. AGE (In years last birthday) 78
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Piney Creek, North Carlina

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John Williams BIRTHPLACE Piney Creek, N.C.

14. MOTHER'S MAIDEN NAME Alpha Pugh BIRTHPLACE North Carolina

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 518 48 4610

17. INFORMANT'S OWN SIGNATURE Mrs. J. Margaret Harper ADDRESS Twin Falls

MEDICAL CERTIFICATION

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 2002 MALIGNANT LYMPHOMA & SPLENOMEGALY — INTERVAL BETWEEN ONSET AND DEATH 1 year

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 11-23-66

19b. MAJOR FINDINGS OF OPERATION MALIGNANT LYMPHOMA OF LYMPH GLANDS IN NECK

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-4-66 19___, *to* 12-28-67, 19___, *that I last saw the deceased alive on* 12-28-67, 19___, *and that death occurred at* NOON *m., from the causes and on the date stated above.*

23a. SIGNATURE Joseph W. Marshall 330 **(Degree or title)** M.D.

23b. ADDRESS Twin Falls, Idaho

23c. DATE SIGNED 12.29.67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE 12.30.67

24c. NAME OF CEMETERY OR CREMATORY Twin Falls Cemetery

24d. LOCATION (City, town, or county) (State) Twin Falls, Idaho 83301

DATE REC'D BY LOCAL REG. 1-3-68

REGISTRAR'S SIGNATURE Pamela J. Johnson

25. EMBALMER Ronald J. Hamilton LICENSE NO. E-470

FIRM NAME: White Mortuary Twin Falls, Ida

Federal Security Agency
United States Public Health Service

Form DH-6202

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

MAR 13 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 4 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5678
Local Reg. No. D-461
Reg. Dist. No. 460

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: 421 Twin Falls 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Twin Falls
c. LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Magic Valley Mem. Hospital 143

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho 420
b. COUNTY: T. Falls
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Twin Falls
d. STREET ADDRESS (If rural, give location): R.R. #2

3. NAME OF DECEASED (Type or Print)
a. (First): GRETTA
b. (Middle): B.
c. (Last): LOCKARD

4. DATE OF DEATH (Month) (Day) (Year): December 29, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed 2
8. DATE OF BIRTH: August 18, 1898
9. AGE (In years last birthday): 69 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Scottsville, Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Lew Blodgett — BIRTHPLACE: Illinois
14. MOTHER'S MAIDEN NAME: Alice Sanford — BIRTHPLACE: Kansas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 538-14-3699
17. INFORMANT'S OWN SIGNATURE: Kimberly, Jim D. Lockard — ADDRESS: Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

416X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Congestive Heart Failure. — INTERVAL BETWEEN ONSET AND DEATH: 2 years

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Rheumatic Heart Disease with — Year
DUE TO (c): Mitral Insufficiency. — Year

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1962, *to* 12/29/, 1967, *that I last saw the deceased alive on* 12/24, 1961, *and that death occurred at* 10:20 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE: Roy O. Shaub 466 M.D. (Degree or title): M.D.
23b. ADDRESS: Twin Falls, Idaho
23c. DATE SIGNED: 1/2/67.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: 1/3/68
24c. NAME OF CEMETERY OR CREMATORY: Twin Falls Cemetery
24d. LOCATION (City, town, or county) (State): Twin Falls, Idaho

DATE REC'D BY LOCAL REG.: 1-2-68
REGISTRAR'S SIGNATURE: Pamela Johnson
25. EMBALMER: Paul D. Reynolds — Paul D. Reynolds
LICENSE NO.: E-495

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Reynolds Funeral Chapel

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5679
Local Reg. No. 43
Reg. Dist. No. 310

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

NOV 9 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY 430 Valley 103
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall, rural
c. LENGTH OF STAY (in this place) 2½ years
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) 3 mi S.E. McCall 000

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 430
b. COUNTY Valley
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) DONALD
b. (Middle) E.
c. (Last) LAWRENCE

4. DATE OF DEATH (Month) (Day) (Year) Nov. 1, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3
8. DATE OF BIRTH Nov. 12, 1967
9. AGE (In years last birthday) 35 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Builder 11
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Wheatland, Wyoming
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Ben Lawrence — BIRTHPLACE Emmett, Nebraska
14. MOTHER'S MAIDEN NAME Marie Rowse — BIRTHPLACE Wyoming

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes — (If yes, give war or dates of service) Korean 7
16. SOCIAL SECURITY NO. 519-26-1352
17. INFORMANT'S OWN SIGNATURE L. Jean Lawrence — ADDRESS McCall, Ida.

9128

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) crushed chest and broken neck — INTERVAL BETWEEN ONSET AND DEATH: instant

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) crushed under heavy equipment
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify) Accident 1
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 3 mi S E McCall 06
21c. (CITY, TOWN, OR TOWNSHIP) 13 McCall — (COUNTY) 430 Valley — (STATE) Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Nov 1, 1967 4 P.m.
21e. INJURY OCCURRED WHILE AT WORK ☒ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR? Loader rolled off road, crushing him

22. *I hereby certify that I attended the deceased from* INVESTIGATION ONLY *19____ to ____, 19____, that I last saw the deceased alive on ____, 19____, and that death occurred at ____ m., from the causes and on the date stated above.*

23a. SIGNATURE Burton E Walker 583 (Degree or title) Coroner 4
23b. ADDRESS Box 376, McCall
23c. DATE SIGNED 4 Nov 67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Nov. 3, 1967
24c. NAME OF CEMETERY OR CREMATORY McCall Cemetery
24d. LOCATION (City, town, or county) McCall, — (State) Idaho

DATE REC'D BY LOCAL REG. Nov-7-1967
REGISTRAR'S SIGNATURE Myrtle M Gardner
25. EMBALMER Burton E Walker — LICENSE NO. E-386

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: WALKER FUNERAL HOME

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

NOV 1 4 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

DEC 2 1 1967

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 1 3 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 1 9 1968

JUN 2 3 1975

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

RECEIVED DEC 13 1967 Bureau of Vital Statistics

STATE OF IDAHO

State File No. 5680
Local Reg. No. 77
Reg. Dist. No. 910

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: 030 Valley 301
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): McCall
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: 020 Adams
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): New Meadows
d. STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print): a. (First) DOUGLAS b. (Middle) WILLIAM c. (Last) BAIN

4. DATE OF DEATH: (Month) December (Day) 1 (Year) 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): child 1
8. DATE OF BIRTH: March 31, 1961
9. AGE (In years last birthday): 6 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child 03
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Council, Idaho
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Earl H. Bain — BIRTHPLACE: Payette, Idaho
14. MOTHER'S MAIDEN NAME: Mary Wavrick — BIRTHPLACE: Weiser, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: Earl N. Bain — ADDRESS: New Meadows, Idaho

MEDICAL CERTIFICATION

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c).

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 5684 Collapse left lung — INTERVAL BETWEEN ONSET AND DEATH: immediate

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) herniation abdominal contents — —
DUE TO (c) Eventration left diaphragm — congenital

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☑ NO ☐

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 11-30 – 1967 *to* 11-30 – 1967, *that I last saw the deceased alive on* 11-30 – 1967, *and that death occurred at* 12^00 *m., from the causes and on the date stated above.*

23a. SIGNATURE: Wayne F. Walker 006 (Degree or title) MD
23b. ADDRESS: McCall Idaho
23c. DATE SIGNED: 12-7-67

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 3, 1967
24c. NAME OF CEMETERY OR CREMATORY: Meadows Valley Cemetery
24d. LOCATION (City, town, or county): Meadows (State): Idaho

DATE REC'D BY LOCAL REG.: Dec 7 1967
REGISTRAR'S SIGNATURE: Myrtle M. Gardner
25. EMBALMER: Burton C. Walker
LICENSE NO.: E-386

Federal Security Agency
United States Public Health Service
Form DH-63021

FIRM NAME: WALKER FUNERAL HOME

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

RECEIVED JAN 15 1968 Bureau of Vital Statistics

Certificate of Death

STATE OF IDAHO

State File No. 5681
Local Reg. No.
Reg. Dist. No.

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley — 201
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) McCall — LENGTH OF STAY (in this place) 3 weeks
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) McCall Memorial Hospital — 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho — 250 — b. COUNTY Idaho
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Riggins
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	ANNIS	MARIE	PRESTWICH	Dec. 23, 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	Nov. 27, 1911	56				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Bookkeeper, retired	19	Van Wyck, Idaho	U.S.A.

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Andrew Nelson	Sweden	Mary Ann Everson	Norway

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		538-03-5567	Lucy L. Prestwich	Riggins, Idaho

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Respiratory obstructive syndrome — INTERVAL BETWEEN ONSET AND DEATH: 36h

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Multiple Sclerosis — 6 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

345X

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED	21f. HOW DID INJURY OCCUR?
m.	WHILE AT WORK ☐ NOT WHILE AT WORK ☐	

22. *I hereby certify that I attended the deceased from* June, 1964, *to* 12-23, 1967, *that I last saw the deceased alive on* 12-23, 1967, *and that death occurred at* 6:30 *a. m., from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
Wayne F. Allen 006	MD	McCall Idaho	1-9-68

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	Dec. 27, 1967	Riggins, Cemetery	Riggins,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Jan 16 1968	Myrtle M. Gardner	Benton C. Walker	E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

APR 7 1971

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 10 1968 Bureau of Vital Statistics

State File No. 5682
Local Reg. No. 48
Reg. Dist. No. 310

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 430 Valley 303
b. CITY OR TOWN McCall
LENGTH OF STAY (in this place) 3 days
d. FULL NAME OF HOSPITAL OR INSTITUTION McCall Memorial Hospital 209

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 430 b. COUNTY Valley
c. CITY OR TOWN McCall
d. STREET ADDRESS (If rural, give location) rural

3. NAME OF DECEASED (Type or Print)
a. (First) MAUDELENE b. (Middle) c. (Last) DAVIS

4. DATE OF DEATH (Month) (Day) (Year) Dec. 25, 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married 3

8. DATE OF BIRTH June 16, 1890

9. AGE (In years last birthday) 77
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Minneapolis, Minnesota

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Bryan Estabrook BIRTHPLACE no record

14. MOTHER'S MAIDEN NAME Nellie Pottenger BIRTHPLACE Sun Ferry, Wis.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 519-56-0262

17. INFORMANT'S OWN SIGNATURE Harold Davis ADDRESS Rt.1, McCall, Idaho

18. CAUSE OF DEATH 2040
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a) BRONCHIAL PNEUMONIA — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) CHRONIC LYMPHOCYTIC LEUKEMIA
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. DIABETES MELLITUS

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Dec. 23, 1967, *to* Dec. 25, 1967, *that I last saw the deceased alive on* Dec. 25, 1967, *and that death occurred at* 8:35A m., *from the causes and on the date stated above.*

23a. SIGNATURE Harold S. Nokes M.D. 391 (Degree or title)

23b. ADDRESS McCall, Idaho

23c. DATE SIGNED 1-4-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY Spink Cemetery

24d. LOCATION (City, town, or county) (State) Valley County, Idaho

DATE REC'D BY LOCAL REG. Jan 7 1968

REGISTRAR'S SIGNATURE Myrtle A. Gardner

25. EMBALMER Burton E Walker LICENSE NO. E-386

FIRM NAME: WALKER FUNERAL HOME

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUN 14 1985

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5683
Local Reg. No. 39
Reg. Dist. No. 330

BIRTH NO.

RECEIVED JAN 9 - 1968

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH

a. COUNTY 44 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser Bureau
c. LENGTH OF STAY (in this place) 153 DAYS
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).

a. STATE Idaho
b. COUNTY 44 Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 1150 E. 4th

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
Pearl	M.	Jackson	12	7	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
female	caucasian	married 3	9/12/1897	70				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	own home	Heppner, Oregon	USA

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
G. W. Thompson	---	Anna Napier	---

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
no		Mrs. Charles E. Jackson	Weiser, Idaho

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4647 Pulmonary Embolus — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Thrombophlebitis

DUE TO (c) Pneumonia

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 11-20, 1967 *to* 12-7, 1967, *that I last saw the deceased alive on* 12-7, 67, *and that death occurred at* 3:25 P.M., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
[signature]	Weiser, Idaho	12-9-67

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	12/11/67	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
12-9-67	[signature]	Marshall S. Dickerson Jr.	E 464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN. 9 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS ~~COMPLETE ALL PARTS OF THIS ITEM.~~ In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5684
Local Reg. No. 37
Reg. Dist. No. 330

BIRTH NO.

DEC 22 1967
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Washington
b. CITY OR TOWN Weiser
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence, 518 E. Court

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 518 E. Court

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)
	JULIA	MAY	NIELAND	Dec. 10 1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Female	White	Married 3	May 14, 1920	47				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife 01	Own home	Jerome, Idaho	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
George I. Sabin	----	----	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
NO		Robert C. Nieland	Weiser

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a)	Hepatic failure 09 2X	3 y
ANTECEDENT CAUSES *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.* DUE TO (b)	Inf. Hepatitis	6 w
DUE TO (c)		
II. OTHER SIGNIFICANT CONDITIONS *Conditions contributing to the death but not related to the disease or condition causing death.*	Multiple Sclerosis	

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)	21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
m.		

22. *I hereby certify that I attended the deceased from* 2/7, 19 67, *to* 12/16, 19 67, *that I last saw the deceased alive on* 12/29, 19 67, *and that death occurred at* 7:45 *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title)	23b. ADDRESS	23c. DATE SIGNED
186	Weiser, Idaho	Dec.10,1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)
Burial	Dec.14,1967	Hillcrest Cemetery	Weiser Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec.10,1967	R. Dee Thomsen	Marshall S. Dickerson Jr.	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

DEC 2 6 1967

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

NOV 3 1978

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5685
Local Reg. No. 41
Reg. Dist. No. 320

Certificate of Death

STATE OF IDAHO

BIRTH NO.

REC'D JAN 12 1968 Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Residence, 1281 W. 2nd

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 1281 W. 2nd

3. NAME OF DECEASED (Type or Print)	a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
	EUGENE	ELLWOOD	HAND	Dec.	19	1967

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
Male	White	widowed 2	June 11, 1887	80				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Rancher 04	Ranching	Fort Ripley, Minnesota	US

13. FATHER'S NAME	BIRTHPLACE	14. MOTHER'S MAIDEN NAME	BIRTHPLACE
Ulysses Grant Hand	----	Rettie Ellwood	----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT'S OWN SIGNATURE	ADDRESS
No			Jack W Hand	Weiser, Ida.

18. CAUSE OF DEATH — Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

7954

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Subject was found dead in his home.

ANTECEDENT CAUSES Had been under a physician's care intermittently.

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) No evidence of foul play. To the best of my knowledge & belief, subject died

DUE TO (c) of natural causes.

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Coroner's investigation, *that I last saw the deceased alive on* ____, 19__, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
R Dale Thomason	583 Ward C. Coroner, 4	Weiser, Idaho	Dec. 19, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county)	(State)
Burial	Dec. 22, 1967	Hillcrest Cemetery	Weiser	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
Dec. 19, 1967	R Dale Thomason	Marshall S. Dickerson	E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 16 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 30 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

State File No. 5686
Local Reg. No. 38
Reg. Dist. No. 320

Certificate of Death

RECEIVED STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington DEC 28 1967 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser Bureau of Vital Statistics
c. LENGTH OF STAY (If in place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital 153

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 441
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print)
a. (First) WALTER
b. (Middle)
c. (Last) PARSONS

4. DATE OF DEATH (Month) (Day) (Year) Dec. 19, 1967

5. SEX Male
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH August 10, 1913
9. AGE (In years last birthday) 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheep herder 04
10b. KIND OF BUSINESS OR INDUSTRY Sheep
11. BIRTHPLACE (State or foreign country) Ford Kyles, Tennessee
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME Sam Parsons — BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME Elizabeth Goins — BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Gary Walter Parsons — ADDRESS Weiser

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4341

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 1. Congestive heart failure 2. Chronic obstructive pulmonary disease.

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 1-20-67, 19__, *to* 12-19-67, 19__, *that I last saw the deceased alive on* 12-19-67, 19__ *and that death occurred at* 3:20a. *m., from the causes and on the date stated above.*

23a. SIGNATURE Thomas R. McDonnell, M. D. (Degree or title) 667
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED Dec.19,1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Dec.21,1967
24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery
24d. LOCATION (City, town, or county) (State) Weiser, Idaho

DATE REC'D BY LOCAL REG. Dec.19.1967
REGISTRAR'S SIGNATURE R. Dee Thomason
25. EMBALMER Marshall S. Dickerson Jr.
LICENSE NO. E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5687
Local Reg. No. 40
Reg. Dist. No. 320

BIRTH NO.

RECEIVED JAN 9 - 1968

1. PLACE OF DEATH
a. COUNTY 441 Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Haven Nursing Home 298

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE Idaho
b. COUNTY 441 Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print)
a. (First) HULDAH
b. (Middle) C.
c. (Last) PEARSON

4. DATE OF DEATH (Month) Dec. (Day) 19 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2

8. DATE OF BIRTH Oct. 22, 1878

9. AGE (In years last birthday) 89
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Perry, Iowa

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME ----
BIRTHPLACE ----

14. MOTHER'S MAIDEN NAME ----
BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Marion W Pearson
ADDRESS Bend, Ore

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) 4438 Chr. Myocarditis

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Hypertension
DUE TO (c) Gen. Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-12-, 1967, *to* 12-19-, 1967, *that I last saw the deceased alive on* 12-19-, 1967, *and that death occurred at* 2:45 p.m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 344 (Degree or title)

23b. ADDRESS Weiser, Idaho

23c. DATE SIGNED Dec.19,1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial

24b. DATE Dec.21,1967

24c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery

24d. LOCATION (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. Dec.19,1967

REGISTRAR'S SIGNATURE R. Dee Thomas

25. EMBALMER Marshall S. Dickenson

LICENSE NO. E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

State File No. 5688
Local Reg. No. 42
Reg. Dist. No. 320

Certificate of Death

STATE OF IDAHO

RECEIVED JAN 9 - 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 44 Washington
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (In this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Weiser Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY 44 Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
d. STREET ADDRESS (If rural, give location) 453 ----

3. NAME OF DECEASED (Type or Print) a. (First) IDA b. (Middle) IRENE c. (Last) KUHLMAN

4. DATE OF DEATH (Month) Dec. (Day) 23 (Year) 1967

5. SEX Female

6. COLOR OR RACE White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) widowed 2

8. DATE OF BIRTH Oct. 6, 1874

9. AGE (In years last birthday) 93 — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Osage County, Kansas

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John Robson — BIRTHPLACE New York

14. MOTHER'S MAIDEN NAME Eliza Mosser — BIRTHPLACE ----

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Thomas A. Reed — ADDRESS Payette

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

4221

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Hypostatic Pneumonia — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Chr. Myocarditis
DUE TO (c) Arteriosclerosis

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-14- , 1967, *to* 12-23- , 1967, *that I last saw the deceased alive on* 12-23- , 1967, *and that death occurred at* 1:35p. m., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 344 (Degree or Title) — **23b. ADDRESS** Weiser, Idaho — **23c. DATE SIGNED** Dec. 23, 1967

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial — **24b. DATE** Dec. 26/67 — **24c. NAME OF CEMETERY OR CREMATORY** Hillcrest Cemetery — **24d. LOCATION** (City, town, or county) Weiser (State) Idaho

DATE REC'D BY LOCAL REG. Dec. 23, 1967 — **REGISTRAR'S SIGNATURE** R. Drew Thomason

25. EMBALMER Marshall S. Dickerson Jr. — **LICENSE NO.** E-464

FIRM NAME: Northam-Jones Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

JAN 10 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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State File No. 5689
Local Reg. No. 43
Reg. Dist. No. 320

Certificate of Death

RECEIVED
JAN 12 1968
Bureau of Vital Statistics

STATE OF IDAHO

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY 441 Washington 000
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Weiser
c. LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Park Haven Nursing Home 288

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho 440
b. COUNTY Washington
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Cambridge
d. STREET ADDRESS (If rural, give location) ----

3. NAME OF DECEASED (Type or Print)
a. (First) MARTHA
b. (Middle) JOHANNA
c. (Last) RUDGER

4. DATE OF DEATH (Month) Dec. (Day) 31 (Year) 1967

5. SEX Female
6. COLOR OR RACE White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Widowed 2
8. DATE OF BIRTH April 7, 1882
9. AGE (In years last birthday) 85 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 01
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Dresden, Germany
12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME John Freudenberg — BIRTHPLACE ----
14. MOTHER'S MAIDEN NAME Johanna Freudenberg — BIRTHPLACE ****

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT'S OWN SIGNATURE Gretchen B. Clelland — ADDRESS Cambridge

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

4200

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Ventric Fibrillation — INTERVAL BETWEEN ONSET AND DEATH 1 hr

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Art. Ht. Disease — 10 y
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Chr. brain syndrome

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 7/26, 1967, *to* 12/31, 1967, *that I last saw the deceased alive on* 12/1, 1967, *and that death occurred at* 10:08 A.M., *from the causes and on the date stated above.*

23a. SIGNATURE [signature] 186 (Degree or title)
23b. ADDRESS Weiser, Idaho
23c. DATE SIGNED Dec.31/67

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE Jan.3, 1968
24c. NAME OF CEMETERY OR CREMATORY Salubria Cemetery
24d. LOCATION (City, town, or county) Salubria (State) Idaho

DATE REC'D BY LOCAL REG. Dec.31/67
REGISTRAR'S SIGNATURE Dave Thomason
25. EMBALMER Marshall S. Dickerson Jr.
LICENSE NO. E-464

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME: Northam-Jones Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JAN 13 1971

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

APR 2 1980

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5690
Local Reg. No. 750
Reg. Dist. No. 370

RECEIVED FEB 8 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (in this place): (9 MO
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): BOISE CONVELSENT CENTER

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: IDAHO
b. COUNTY: ADA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 720 PUEBLO

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month)	(Day)	(Year)
XENIA	LOUSIA	HOYT	12/	23/	67

5. SEX	6. COLOR OR RACE	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
FEMALE	WHITE	WIDOWED	2/10/1881	86	10	14		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSE WIFE
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): ST. DEROIN NEBRASKA
12. CITIZEN OF WHAT COUNTRY? US.

13. FATHER'S NAME: ELISHA M. BAKER — BIRTHPLACE: COLUMBIA, OHIO
14. MOTHER'S MAIDEN NAME: SERELDA O. TAYLOR ANDREWSCO. — BIRTHPLACE: MISSOURI

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 518-10-7184
17. INFORMANT'S OWN SIGNATURE: Russell C Relyea — ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): 486X Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 1 wk

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic Heart Disease

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 1957, *to* Dec _____, 1967, *that I last saw the deceased alive on* Dec 14, 1967, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): George R Baker
23b. ADDRESS: 121 E Idaho Boise
23c. DATE SIGNED:

24a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
24b. DATE: 12/28/67
24c. NAME OF CEMETERY OR CREMATORY: SYRINGA GARDENS
24d. LOCATION (City, town, or county) (State): BOISE, ADA IDAHO

DATE REC'D BY LOCAL REG.: Feb 2 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: CONWAY GRAN[illegible]
LICENSE NO.: E478
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service
Form DH-63021

Permanent, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

67-11981 RECEIVED

Certificate of Death

STATE OF IDAHO

State File No. 5691
Local Reg. No. 749
Reg. Dist. No. 370

BIRTH NO.

FEB 5 1968
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: Ada
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Boise
c. LENGTH OF STAY (in this place): 2days
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): St. Lukes Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Boise
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Horseshoe Bend
d. STREET ADDRESS (If rural, give location): Box 51

3. NAME OF DECEASED (Type or Print)
a. (First): Lucinda
b. (Middle): Allene
c. (Last): Mofford

4. DATE OF DEATH (Month) (Day) (Year): Dec.25,1967

5. SEX: female
6. COLOR OR RACE: white
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): never married
8. DATE OF BIRTH: Dec.9,1967
9. AGE (In years last birthday): IF UNDER 1 YEAR Months / Days: 16; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): child
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Emmett, Idaho
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Willard Mofford
BIRTHPLACE: Spokane, Wash.
14. MOTHER'S MAIDEN NAME: Rose Fenton
BIRTHPLACE: Emmett, Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT'S OWN SIGNATURE: X Willard F Mofford
ADDRESS:

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

474 X

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Influenza — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Encephalitis — 2 days

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☒ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 12-23, 1967, *to* 12-25, 1967, *that I last saw the deceased alive on* 12-24, 1967, *and that death occurred at* 4:30 A.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] MD
23b. ADDRESS: 200 E Bannock Boise
23c. DATE SIGNED: 1-26-68

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec.28,1967
24c. NAME OF CEMETERY OR CREMATORY: Pioneer
24d. LOCATION (City, town, or county) (State): Horseshoe Bend, Idaho

DATE REC'D BY LOCAL REG.: Feb. 1 1968
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E392
FIRM NAME: The Beatty Chapel

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5692
Local Reg. No. 782
Reg. Dist. No. 610

RECEIVED JAN 30 1968 Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
c. LENGTH OF STAY (In this place): ?
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Rogers Hotel

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, Idaho
d. STREET ADDRESS (If rural, give location): Rogers Hotel

3. NAME OF DECEASED (Type or Print): a. (First) HOWARD b. (Middle) PALMER c. (Last) DUNNING

4. DATE OF DEATH (Month) (Day) (Year): about Dec. 9-1967

5. SEX: Male

6. COLOR OR RACE: Cauc.

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Unknown

8. DATE OF BIRTH: Feb. 4, 1912

9. AGE (In years last birthday): 55
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: General

11. BIRTHPLACE (State or foreign country): Eden, Texas

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: George W. Dunning
BIRTHPLACE: Texas

14. MOTHER'S MAIDEN NAME: Mary M. Gibson
BIRTHPLACE: Texas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Ukn.
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: Ukn.

17. INFORMANT'S OWN SIGNATURE: Mrs Ruby Livesman
ADDRESS: Junction Ty

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): PNEUMONITIS WITH CONGESTION & EDEMA SEVERE, LUNGS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b): ETIOLOGY UNDETERMINED

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.: DERMATITIS, MACULO-VESICULAR AND EXFOLIATIVE IN LOWER EXTERMITIES GENERALIZED

INTERVAL BETWEEN ONSET AND DEATH: DAYS

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify): NONE

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS BONNEVILLE IDAHO

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19___, *to* _____, 19___, *that I last saw the deceased alive on* _____, 19___, *and that death occurred at* _____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): HAZEL L. MC GAFFEY, M. D. CORONER

23b. ADDRESS: 2525 SOUTH BOULEVARD IDAHO FALLS

23c. DATE SIGNED: 1/12/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: Dec. 18, 67

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: Jan. 25-68

REGISTRAR'S SIGNATURE: Anna Budge

25. EMBALMER: Lee Sullivan

LICENSE NO.: E387

FIRM NAME: Buck Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician THIS 55 YEAR OLD WHITE MALE WAS FOUND DEAD IN A BED IN THE ROGER'S HOTEL OF IDAHO FALLS...AND WAS CHECKED IN UNDER ANOTHER NAME. THE FINDING SUGGEST EITHER AN ACUTE INFECTION OR ACUTE ANAPHYLACTIC ALLERGIC REACTION OCCURED TO CAUSE DEATH. CONSIDERABLE AUTOLYSIS OF TISSUES MADE EVALUATION DIFFICULT. HE WAS PROBABLY DEAD ABOUT 2 DAYS BEFORE DISCOVERED. TOXICOLOGICAL STUDIES WERE NEG.

Certificate of Death

STATE OF IDAHO

State File No. 5693
Local Reg. No. 787
Reg. Dist. No. 610

RECEIVED JAN 30 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
LENGTH OF STAY (in this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 957 Poulson

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bonneville
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls
d. STREET ADDRESS (If rural, give location): 957 Poulson

3. NAME OF DECEASED (Type or Print): a. (First) Bette b. (Middle) Pearl c. (Last) Ogle

4. DATE OF DEATH: (Month) (Day) (Year) December 30 1967

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: August 19, 1923

9. AGE (In years last birthday): 44
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Accounting

11. BIRTHPLACE (State or foreign country): Wenatchee, Washington

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Alfred Foster
BIRTHPLACE: Oregon

14. MOTHER'S MAIDEN NAME: Minnie Webb
BIRTHPLACE: Kentucky

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 537 16 0933

17. INFORMANT'S OWN SIGNATURE: Richard D. Ogle
ADDRESS: San Angelo, Texas

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

*This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) SUDDEN UNEXPECTED DEATH, ~~UNDETERMINED~~ MD

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) CYSTIC EPENDYMOMA, OBSTRUCTIVE TO AQUEDUCT OF SYLVIUS, THIRD VENTRICLE TUMOR

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

1) HYPERPOTASSEMIA FOUND IN SERUM (PROBABLY INTRA* CELLULAR AS WELL AS EXTRACELLULAR) MAY HAVE CAUSED A CARDIAC ARRHYTHMIA & ARREST.

2) THYROIDITIS, LYMPHOCYTIC, SEVERE, TREATED BY THYROXIN 4 GRAINS DAILY.

INTERVAL BETWEEN ONSET AND DEATH: DIED ~~OVERNITE~~ SYMPTOMATIC ABOUT 3 WEEKS

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): NONE

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): IDAHO FALLS BONNEVILLE IDAHO

21d. TIME OF INJURY: (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED: WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* _____, 19____, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hazel L. McGaffeyk M. D. CORONER

23b. ADDRESS: 2525 SOUTH BOULEVARD - IDAHO FALLS

23c. DATE SIGNED: 1/12/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 1/3/68

24c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery

24d. LOCATION (City, town, or county) (State): Idaho Falls Idaho

DATE REC'D BY LOCAL REG.: Jan. 26 - 68

REGISTRAR'S SIGNATURE: Irma Rudgin

25. EMBALMER: Ralph M. Wood

LICENSE NO.: 413

FIRM NAME: Wood Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5694
Local Reg. No.
Reg. Dist. No. 540

BIRTH NO.

RECEIVED JAN 26 1968 Bureau of Vital Statistics

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Franklin
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Preston
c. LENGTH OF STAY (in this place): 10 Min.
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): General Memorial

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Winder
d. STREET ADDRESS (If rural, give location): None

3. NAME OF DECEASED (Type or Print): a. (First) David b. (Middle) LeRoy c. (Last) Johnson

4. DATE OF DEATH (Month) (Day) (Year): December 28, 1967

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: February 7, 1911

9. AGE (In years last birthday): 56 — If under 1 year: Months / Days — If under 24 hrs.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Dairying

11. BIRTHPLACE (State or foreign country): Preston, Idaho

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Julius Johnson — BIRTHPLACE: Burns, Minnesota

14. MOTHER'S MAIDEN NAME: Marian Jensen — BIRTHPLACE: Sora, Denmark

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 528-09-3997

17. INFORMANT'S OWN SIGNATURE: Enid J. Johnson — ADDRESS: Preston, Idaho

4109

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b):

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* ____, 19__ *to* ____, 19__, *that I last saw the deceased alive on* 12/28, 19 67, *and that death occurred at* 9 a.m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Leo R. Hawkes M.D.

23b. ADDRESS: Preston Idaho

23c. DATE SIGNED: 1/9/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial

24b. DATE: 12-30-67 Dec. 28, 1967

24c. NAME OF CEMETERY OR CREMATORY: Preston Cemetery

24d. LOCATION (City, town, or county) (State): Preston, Idaho

DATE REC'D BY LOCAL REG.: 1-9-68

REGISTRAR'S SIGNATURE: Effie W. Brower

25. EMBALMER: O. Sherwin Webb — **LICENSE NO.**: 316

FIRM NAME: Webb Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-69021

DUTIES:

APR 24 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under Items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Amended

RECEIVED

Certificate of Death

STATE OF IDAHO

JAN 26 1968

Bureau of Vital Statistics

State File No. 5695
Local Reg. No. 313
Reg. Dist. No. 220

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Lewiston Orchards
c. LENGTH OF STAY (in this place): 1day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 14th & Ripon

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Tammany
d. STREET ADDRESS (If rural, give location): Rural Rte #1

3. NAME OF DECEASED (Type or Print)
a. (First): Sidney
b. (Middle): Fay
c. (Last): Schwank

4. DATE OF DEATH (Month) (Day) (Year): Dec. 27, 1967

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Dec 27, 1938
9. AGE (In years last birthday): 29 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: at home
11. BIRTHPLACE (State or foreign country): Stockton
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Sidney Simon — BIRTHPLACE: Vermont
14. MOTHER'S MAIDEN NAME: Marion Schmidt — BIRTHPLACE: No record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 552-54-8826
17. INFORMANT'S OWN SIGNATURE: [signature] — ADDRESS: Lewiston, Idaho

8129

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a): Shock and Hemhorrage

ANTECEDENT CAUSES — *Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.*

DUE TO (b): Auto Accident injuries

DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS — *Conditions contributing to the death but not related to the disease or condition causing death.*

INTERVAL BETWEEN ONSET AND DEATH:

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Roadway
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): 14th and Ripon Lewiston Orchards NezPerce Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12/27/67 7:45PM
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?: Auto Collision

22. *I hereby certify that I attended the deceased from* 6666, 19__ *to* **, 19__, *that I last saw the deceased alive on* _____, 19__, *and that death occurred at* 7:45PM *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): [signature] Coroner
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 1/20/68

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec.30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Lewis Clark Memorial Gardens
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-19-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: V. Vasser [signature]
LICENSE NO.: E297

Federal Security Agency
United States Public Health Service

Form DH-63021

FIRM NAME: Vassar-Rawls Funeral Home

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

To the Depart;emt of Health, State of Idaho

I hereby certify that the death of Sidney Fay SCHWANK was due an Auto ACCIDENT on Dec, 27,1967. The origional Death Certificate which stated it was Suicide, was in error.

Andrew F. Vassar
signed

RECEIVED
JAN 26 1968
Bureau of V

To the Department Of Health, State of Idaho.

I hereby certify that the death of Sidney Fay SCHWANK on Dec. 27, 1967 was caused by accident and was not a Suicide a s was stated on the origicnal death certificate. This certificate was inclmplete and in error.

Lonnie Grimm
signed
Investigating Officer

Signatures Witnessed by.
Wilfred J. Duclos

To the Department of Health, State of Idaho

I hereby certify that the death of Sidney Ray [illegible] was due an Auto ACCIDENT on Dec. 27, 1967. The original death certificate which stated it was Suicide, was in error.

[illegible]

I hereby certify that the death of [illegible] Ray [illegible] on Dec. 27, 1967 was caused by accident and was not a suicide as was stated on the original death certificate. This certificate was incomplete and in error.

[illegible]

Certificate of Death

STATE OF IDAHO

State File No.
Local Reg. No. 313
Reg. Dist. No. 220

BIRTH NO.

RECEIVED JAN 10 1968 Vital Statistics Bureau

1. PLACE OF DEATH
a. COUNTY: Nez Perce
b. CITY OR TOWN (If outside corporate limits, write RURAL and give Township): Lewiston Orchards
c. LENGTH OF STAY (in this place): 1 day
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): 14th & Ripon

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Nez Perce
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rural Tammany
d. STREET ADDRESS (If rural, give location): rural Rte #1

3. NAME OF DECEASED (Type or Print)
a. (First): Sidney
b. (Middle): Fay
c. (Last): Schwank

4. DATE OF DEATH (Month) (Day) (Year): Dec. 27, 1967

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: Dec. 27, 1938

9. AGE (In years last birthday): 29
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY: at home

11. BIRTHPLACE (State or foreign country): Stockton

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Sidney Simon
BIRTHPLACE: Vermont

14. MOTHER'S MAIDEN NAME: Marion Schmidt
BIRTHPLACE: no record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 552-54-8826

17. INFORMANT'S OWN SIGNATURE: Fay J. Schwank
ADDRESS: Lewiston, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Shock + Hemorrage
INTERVAL BETWEEN ONSET AND DEATH: MOMENTS

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b):
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 12-27-67 7:45 P. m.
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR?:

22. *I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 7:45 P. m., from the causes and on the date stated above.*

23a. SIGNATURE: Wilfred J. Duclos
(Degree or title): Coroner
23b. ADDRESS: Lewiston, Idaho
23c. DATE SIGNED: 1-1-68

24a. BURIAL, CREMATION, REMOVAL (Specify): burial
24b. DATE: Dec. 30, 1967
24c. NAME OF CEMETERY OR CREMATORY: Lewis Clark Memorial Gardens
24d. LOCATION (City, town, or county) (State): Lewiston, Idaho

DATE REC'D BY LOCAL REG.: 12-29-67
REGISTRAR'S SIGNATURE: Lynette Knott
25. EMBALMER: V. Vasser
LICENSE NO.: E297

FIRM NAME: Vassar-Rawls Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 218.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

JAN 11 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JAN 26 1968

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signature of the INFORMANT and the OFFICIAL last in attendance on the deceased.

FEB 1 1968

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

MAR 6 1969

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Certificate of Death

STATE OF IDAHO

State File No. 5697
Local Reg. No.
Reg. Dist. No. 610

RECEIVED Bureau of Vital Statistics

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY Bonneville APR 9 1968
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Idaho Falls
LENGTH OF STAY (in this place)
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Sacred Heart Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE Idaho
b. COUNTY Bonneville
c. CITY (If outside corporate limits, write RURAL and give township) OR TOWN Idaho Falls
d. STREET ADDRESS (If rural, give location) 1210 Kearney

3. NAME OF DECEASED (Type or Print)
a. (First) HENRY
b. (Middle) JAMES
c. (Last) ACKARET

4. DATE OF DEATH (Month) (Day) (Year) June 27, 1967

5. SEX male

6. COLOR OR RACE white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) married

8. DATE OF BIRTH Dec 9, 1907

9. AGE (In years last birthday) 59
IF UNDER 1 YEAR Months 6 Days 18
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Ogden, Utah

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME ?
BIRTHPLACE

14. MOTHER'S MAIDEN NAME ?
BIRTHPLACE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT'S OWN SIGNATURE Margaret Ackaret
ADDRESS 218 So. Water City

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Generalized carcinoma — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Metastasis from the stomach — 2 months
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES [X] NO [ ]

21a. ACCIDENT SUICIDE HOMICIDE (Specify)

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE) Idaho Falls, Bonneville, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 6-14, 1965, *to* 6-27, 1967, *that I last saw the deceased alive on* 6-27, 1967, *and that death occurred at* ____ m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title) [illegible] M.D.
23b. ADDRESS Idaho Falls, Idaho
23c. DATE SIGNED 4-2-68

24a. BURIAL, CREMATION, REMOVAL (Specify) Burial
24b. DATE June 30, 1967
24c. NAME OF CEMETERY OR CREMATORY Rosehill cemetery
24d. LOCATION (City, town, or county) (State) Idaho Falls, Idaho

DATE REC'D BY LOCAL REG. April 6-1968
REGISTRAR'S SIGNATURE [illegible]

25. EMBALMER Leo A. Williams
LICENSE NO. E-319

FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service
Form DH-63021

APR 12 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

JUL 6 1973

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

Certificate of Death

STATE OF IDAHO

State File No. 5698
Local Reg. No. 756
Reg. Dist. No. 611

RECEIVED JUN 18 1968 Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Bonneville
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Idaho Falls, (Rural)
DURATION OF STAY (in this place): 11 months
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location):

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Idaho
b. COUNTY: Bingham
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Fort Hall
d. STREET ADDRESS (If rural, give location): Box 201, Fort Hall

3. NAME OF DECEASED (Type or Print): a. (First) Rodger; b. (Middle) Mack; c. (Last) Prisock

4. DATE OF DEATH (Month) (Day) (Year): Found May 20, 1968

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): divorced

8. DATE OF BIRTH: December 15, 1939

9. AGE (In years last birthday): 26 | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Agriculture

11. BIRTHPLACE (State or foreign country): Blackfoot, Idaho

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: B. E. Prisock — BIRTHPLACE: Canton, Missippi

14. MOTHER'S MAIDEN NAME: Marjorie Gibbons — BIRTHPLACE: Davenport, Iowa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): 1957 to 1961

16. SOCIAL SECURITY NO.: 518-44-4512

17. INFORMANT'S OWN SIGNATURE: B. E. Prisock — ADDRESS: Fort Hall, Idaho

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): PROBABLE DROWNING, ACCIDENTAL (6/9/67) — INTERVAL BETWEEN ONSET AND DEATH

ANTECEDENT CAUSES (SKELETON FOUND IN SNAKE RIVER 1 YEAR AFTER DEATH)

Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b)

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. UNKNOWN

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT SUICIDE HOMICIDE (Specify): ACCIDENT

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased ~~from~~* May 20, , 19 68 *to* xxxxxxxxxxx, *that I have seen the deceased* xxxxxxxxxxxxxxxxxx, *and that death occurred at* ____ *m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Hazel L. McGaffey, M.D. Coroner

23b. ADDRESS: Idaho Falls, Idaho

23c. DATE SIGNED: May 24, 68

24a. BURIAL, CREMATION, REMOVAL (Specify): burial

24b. DATE: May 24, 1968

24c. NAME OF CEMETERY OR CREMATORY: Grove City Cemetery

24d. LOCATION (City, town, or county) (State): Blackfoot Idaho

DATE REC'D BY LOCAL REG.: June 19-68

REGISTRAR'S SIGNATURE: Irma Bridges

25. EMBALMER: L. Dean Hill — LICENSE NO.: E-466

FIRM NAME: Sandberg-Hill Funeral Home

Federal Security Agency
United States Public Health Service

Form DH-63021

DUTIES:

AUG 28 1968

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

MAR 26 1969

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

OCT 11 1977

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician THIS CASE WAS EXTENSIVELY INVESTIGATED AS A "MISSING PERSON" IN JUNE AND JULY, 1967 BY SHERRIF MICKELSON OF BONNEVILLE CO. NO INDICATION FOR FOUL PLAY WAS DISCOVERED. THIS MAN LEFT CAMP ALONE THE NITE OF 6/9/67 AND WAS THOUGHT TO HAVE FALLEN INTO THE SNAKE RIVER AT NITE. THE BODY WAS FOUND 5/20/68 AS A SKELETON. MD

State File No. 67-5699
Local Reg. No.
Reg. Dist. No.

Certificate of Death

STATE OF IDAHO

RECEIVED
JUN 26 1968
Bureau of Vital Statistics

BIRTH NO.

1. PLACE OF DEATH
a. COUNTY: Lemhi
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): near Indianola Ranger Station *
LENGTH OF STAY (in this place): 0
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): (*near Shoup, Idaho

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: California
b. COUNTY: Merced
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township): South Dos Palos
d. STREET ADDRESS (If rural, give location): assumed to be

3. NAME OF DECEASED (Type or Print)
a. (First): Henry
b. (Middle): Izia
c. (Last): High

4. DATE OF DEATH (Month) (Day) (Year): July 1, 1967

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Married
8. DATE OF BIRTH: Sept. 22, 1912
9. AGE (In years last birthday): 54 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Welder
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Baker, Idaho
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Carl High — BIRTHPLACE: unknown
14. MOTHER'S MAIDEN NAME: Lena Bohannon — BIRTHPLACE: Idaho

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes — (If yes, give war or dates of service): WW #2
16. SOCIAL SECURITY NO.: yes
17. INFORMANT'S OWN SIGNATURE — ADDRESS

8160

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Assumed asphyxiation by drowning

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) (body not recovered)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

19a. DATE OF OPERATION
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT SUICIDE HOMICIDE (Specify): Accident
21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Forest Highway
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Shoup, Lemhi, Idaho
21d. TIME OF INJURY (Month) (Day) (Year) (Hour): 7-1-67 m.
21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒
21f. HOW DID INJURY OCCUR? See attached papers

22. *I hereby certify that I attended the deceased from _____, 19__, to _____, 19__, that I last saw the deceased alive on _____, 19__, and that death occurred at _____ m., from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Delbert E. Louis Lemhi Co. Coroner
23b. ADDRESS: Salmon Ida
23c. DATE SIGNED: June 24, 1968

24a. BURIAL, CREMATION, REMOVAL (Specify)
24b. DATE
24c. NAME OF CEMETERY OR CREMATORY
24d. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REG.: 6-26-1968
REGISTRAR'S SIGNATURE: W. Benson
25. EMBALMER
LICENSE NO.

Federal Security Agency
United States Public Health Service
Form DH-63021
FIRM NAME:

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

JUL 1 1968

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

WILLIAM BAKER, SHERIFF

OFFICE OF THE SHERIFF

GEORGE NICHOLS, DEPUTY

LEMHI COUNTY

SALMON, IDAHO - 83467

RECEIVED

JUN 2 6 1968

Bureau of Vital Statistics

TO WHOM IT MAY CONCERN:

On July 6, 1967 I was notified of a vehicle in the Salmon River 8.9 miles West of Northfork, Idaho. Investigation revealed the vehicle, a 1967 Chevrolet pickup had been traveling East on the Salmon River Road, ran off the road on a sharp left hand turn and had been washed across the river to the far bank, water was too deep to attempt recovery at that time. On July 14, 1967 with aid of a boat and wrecker the vehicle was removed from the river. Further searching of the islands downstream revealed the body of a middle aged woman who was later identified as that of [redacted] Lena Bartlett 74, of Salmon, Idaho. [redacted] Owner of vehicle was Henry High 54 of Salmon, he is also presumed to [redacted] have been the driver at the time the accident happened. Body of Henry High has never been recovered. Time of accident was the evening of June 30, 1967.

Dated this 21st day of June, 1968.

William T. Baker

Sheriff Lemhi County

JUL 1 1968

Certificate of Death

RECEIVED STATE OF IDAHO

1967
State File No. 5700
Local Reg. No. 62
Reg. Dist. No. 6-30

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to DIVISION OF VITAL STATISTICS, BOISE, IDAHO

1. PLACE OF DEATH
a. COUNTY: Madison
NOV 25 1968
Bureau of Vital Statistics
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Rexburg
c. LENGTH OF STAY (In this place): Unknown
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): None

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission).
a. STATE: Unknown
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give township)
d. STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED (Type or Print): a. (First) John; b. (Middle); c. (Last) DeShane

4. DATE OF DEATH: (Month) 3 (Day) 25 (Year) 67

5. SEX: Male

6. COLOR OR RACE: Indian

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Not known

8. DATE OF BIRTH: 9.10.28 ?

9. AGE (In years last birthday): 38 — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Chinle, Arizona

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME C# 70470: Goldtooth Descheenie ?
BIRTHPLACE: Unknown

14. MOTHER'S MAIDEN NAME C# 70471: Mary Descheenie ?
BIRTHPLACE: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service) # 39866390

16. SOCIAL SECURITY NO.: 726-16-8654

17. INFORMANT'S OWN SIGNATURE: Reservation Police - etc.
ADDRESS

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b), and (c)

**This does not mean the mode of dying, such as heart failure, asthenia, etc. It means the disease, injury, or complication which caused death.*

John Deschene

MEDICAL CERTIFICATION

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH*(a): Cremation
899X

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b): Unknown
DUE TO (c):

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

INTERVAL BETWEEN ONSET AND DEATH

FBI report

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify): Unknown

21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): Rexburg, Idaho

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE): Rexburg, Madison, Idaho

21d. TIME OF INJURY (Month) (Day) (Year) (Hour): March 25 1967 ?m.

21e. INJURY OCCURRED: WHILE AT WORK ☐ NOT WHILE AT WORK ☒

21f. HOW DID INJURY OCCUR?: Unknown

22. *I hereby certify that I attended the deceased from* 3-25-67 ?, *to* _____, 19____, *that I last saw the deceased alive on* _____, 19____, *and that death occurred at* _____ ? m., *from the causes and on the date stated above.*

23a. SIGNATURE (Degree or title): Ed Richardson M.T. Coroner

23b. ADDRESS: Rexburg, Idaho

23c. DATE SIGNED: 11-19-68

24a. BURIAL, CREMATION, REMOVAL (Specify): Removal

24b. DATE: 3-27-68

24c. NAME OF CEMETERY OR CREMATORY: unknown

24d. LOCATION (City, or county) (State): Winslow Arizona

DATE REC'D BY LOCAL REG.: 11-21-68

REGISTRAR'S SIGNATURE: Lona Flamm

25. FUNERAL DIRECTOR: none

ADDRESS

Federal Security Agency
United States Public Health Service

Form DPH-48021

DEC 10 1968

NOV 26 1968

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.

2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT, the OFFICIAL last in attendance on the deceased and HIS OWN signature.

3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES IN BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED-CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The international classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

This body embalmed under direction of..... Lic. No..... at..... on.....

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

RECEIVED FEB 20 1970 Bureau of Vital Statistics

1967 State File No. 5701

Local Reg. No.

Reg. Dist. No. 370

BIRTH NO.

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH
a. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
c. LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): MITCHELL HOTEL, Residence

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO b. COUNTY: ADA
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): BOISE
d. STREET ADDRESS (If rural, give location): 235 So. 10th

3. NAME OF DECEASED (Type or Print): a. (First) JOHN b. (Middle) FRANKLIN c. (Last) DALEY

4. DATE OF DEATH: (Month) (Day) (Year) APRIL 15, 1967

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): unknown

8. DATE OF BIRTH: unknown

9. AGE (In years last birthday): 87
IF UNDER 1 YR. Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): no record

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): no record

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: no record
BIRTHPLACE:

14. MOTHER'S MAIDEN NAME: no record
BIRTHPLACE:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no record
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 518 14 2210

17. INFORMANT'S OWN SIGNATURE: Relyea Mortuary by [signature]
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Probable Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Brief

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):
21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):
21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:
21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* Did Not See Alive, 19, *that I last saw the deceased alive on* , 19, *and that death occurred at* 10P. m., *from the causes and on the date stated above.*

23a. SIGNATURE: E. D. Paris (Degree or title): Coroner
23b. ADDRESS: 3720 Meadow Drive, Boise
23c. DATE SIGNED: 2-14-70.

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: April 17
24c. NAME OF CEMETERY OR CREMATORY: Syringa Gardens
24d. LOCATION (City, town, or county) (State): Boise, Idaho

DATE REC'D BY LOCAL REG.: Feb. 19 1970
REGISTRAR'S SIGNATURE: Myrtle Palmer
25. EMBALMER: [signature]
LICENSE NO.: E-460
FIRM NAME: Relyea Mortuary

Federal Security Agency
United States Public Health Service FORM DH-63021

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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Certificate of Death
STATE OF IDAHO

67-

State File No. 5702
Local Reg. No. 750
Reg. Dist. No. 610

BIRTH NO.

RECEIVED
JUN 5 - 1970
Bureau of Vital Statistics

1. PLACE OF DEATH
a. COUNTY: BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
LENGTH OF STAY (In this place):
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): L.D.S. HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.)
a. STATE: IDAHO
b. COUNTY: BONNEVILLE
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): IDAHO FALLS
d. STREET ADDRESS (If rural, give location): CONVELESCENT HOME. L.D.S.

3. NAME OF DECEASED (Type or Print): a. (First) MARTIN b. (Middle) LEROY c. (Last) BEE

4. DATE OF DEATH: (Month) (Day) (Year) Dec. 2, 1967

5. SEX: male

6. COLOR OR RACE: white

7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: June 17, 1884

9. AGE (In years last birthday): 83
IF UNDER 1 YR. Months: 5 Days: 15 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer retired

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Bountiful, Utah

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: John Moxey Bee
BIRTHPLACE: Scotland

14. MOTHER'S MAIDEN NAME: Georgenna Mc Kensey
BIRTHPLACE: Scotland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT'S OWN SIGNATURE: Mrs Laura Karlson
ADDRESS:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH
Enter only one cause per line for (a), (b) and (c).

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Acute

ANTECEDENT CAUSES
Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.
DUE TO (b) Pulmonary Emphysema — 4 years
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Pernicious Anemia — years

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT / SUICIDE / HOMICIDE (Specify):

21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.):

21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE):

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) m.:

21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21f. HOW DID INJURY OCCUR?

22. *I hereby certify that I attended the deceased from* 3-14-66, 19__, *to* 12-2, 19 67, *that I last saw the deceased alive on* 12-2-67, 19__, *and that death occurred at* __ m., *from the causes and on the date stated above.*

23a. SIGNATURE: [signature] (Degree or title): MD
23b. ADDRESS: Idaho Falls Idaho
23c. DATE SIGNED: 5/29/70

24a. BURIAL, CREMATION, REMOVAL (Specify): Burial
24b. DATE: Dec. 5, 1967
24c. NAME OF CEMETERY OR CREMATORY: Rosehill Cemetery
24d. LOCATION (City, town, or county) (State): Idaho Falls, Idaho

DATE REC'D BY LOCAL REG.: June 2-1970
REGISTRAR'S SIGNATURE: Irma Bridges
25. EMBALMER: Leo A Williams
LICENSE NO.: E-319
FIRM NAME: Williams Funeral Home

Federal Security Agency
United States Public Health Service FORM DH-63021

Informant, Funeral Director, Registrar and Medical Attendant. EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

JUN 9 1970

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

-OCS

ADDITIONAL REMARKS by Physician.....

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Certificate of Death

STATE OF IDAHO

1967 State File No. 5703

Local Reg. No. 72

Reg. Dist. No.

BIRTH NO.

RECEIVED JUL 26 1974 BUREAU OF VITAL STATISTICS

Informant, Funeral Director, Registrar and Medical Attendant: EACH must sign with BLACK INK in OWN handwriting. Each item should be answered as completely as possible. State answers as unknown only after a careful investigation. Use BLACK ink or BLACK record typewriter ribbon in filling out certificate. (ICA 38-206 and 215.) Address correspondence to BUREAU OF VITAL STATISTICS, BOISE, IDAHO.

1. PLACE OF DEATH a. COUNTY: Bonner			2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission.) a. STATE: Idaho	b. COUNTY: Bonner
b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint	c. LENGTH OF STAY (In this place): 5 1/2 Mos		b. CITY OR TOWN (If outside corporate limits, write RURAL and give township): Sandpoint	
d. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location): Bonner General Hospital			c. STREET ADDRESS (If rural, give location): Lakeside	

3. NAME OF DECEASED (Type or Print) a. (First)	b. (Middle)	c. (Last)	4. DATE OF DEATH (Month) (Day) (Year)	
GEORGIA	H.	DOUGHERTY	Mar. 31, 1967	
5. SEX: Female	6. COLOR OR RACE: White	7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify): Widowed	8. DATE OF BIRTH: Nov. 25, 1882	9. AGE (In years last birthday): 84 — IF UNDER 1 YR. Months -- Days -- — IF UNDER 24 HRS. Hours -- Min. --
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife	10b. KIND OF BUSINESS OR INDUSTRY: Own Home	11. BIRTHPLACE (State or foreign country): Russia	12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: George Hill	BIRTHPLACE: Germany	14. MOTHER'S MAIDEN NAME: Unobtainable	BIRTHPLACE: Germany	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.: 519-60-9204 T	17. INFORMANT'S OWN SIGNATURE: Records	ADDRESS	

MEDICAL CERTIFICATION

18. CAUSE OF DEATH

Enter only one cause per line for (a), (b) and (c)

This does not mean the mode of dying, such as heartfailure, asthenia, etc. It means the disease, injury, or complication which caused death.

I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH *(a) Terminal Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days

ANTECEDENT CAUSES Morbid conditions, if any, giving rise to the above cause (a) stating the underlying cause last.

DUE TO (b) Metastatic Adenocarcinoma

DUE TO (c) Original site unknown

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes ☐ No ☒

21a. ACCIDENT SUICIDE HOMICIDE	(Specify)	21b. PLACE OF INJURY (e.g., In or about home, farm, factory, street, office bldg., etc.)	21c. (CITY, TOWN, OR TOWNSHIP)	(COUNTY)	(STATE)
-	-	-	-	-	-

21d. TIME OF INJURY (Month)	(Day)	(Year)	(Hour)	21e. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21f. HOW DID INJURY OCCUR?
-	-	-	- m.		- - - - -

22. I hereby certify that I attended the deceased from ____, 19__ to Mar 31, 1967, that I last saw the deceased alive on 3/31/67, 19__, and that death occurred at 7:05 A.M., from the causes and on the date stated above.

23a. SIGNATURE	(Degree or title)	23b. ADDRESS	23c. DATE SIGNED
J. Munson	MD	Sandpoint Ida	7-25-74

24a. BURIAL, CREMATION, REMOVAL (Specify)	24b. DATE	24c. NAME OF CEMETERY OR CREMATORY	24d. LOCATION (City, town, or county) (State)	
Burial	Apr. 4, 1967	Pinecrest Memorial Park	Sandpoint,	Idaho

DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	25. EMBALMER	LICENSE NO.
July 25 1974	Ramona Spickelmier	Dace & Collett	E-501

FIRM NAME:

Federal Security Agency
United States Public Health Service FORM DH-63021

MAR 1 1 1975

DUTIES:

1. INFORMANT SHALL SIGN HIS OWN NAME, under Item 17 to authenticate the facts stated under items 1 to 16 inclusive. In case of facts taken from hospital or public records, the person authorized to release the facts shall sign HIS name in addition to giving the source of information.
2. THE FUNERAL DIRECTOR is responsible for completing the entire certificate, obtaining the signatures of the INFORMANT and the OFFICIAL last in attendance on the deceased.
3. THE REGISTRAR can issue a burial or removal permit ONLY after receiving a completed death certificate, including the SIGNATURES in BLACK ink under items 17, 23a and 25.

PENALTIES: Under the Idaho law, it is a misdemeanor to

(a) Knowingly supply false information to any one connected with completing a death certificate;
(b) Neglect or refuse to certify to the cause of death on request of the person in charge of the disposition of the deceased.
(c) Remove or bury the body of a deceased person WITHOUT the proper permit being FIRST obtained from the local registrar in the district WHERE THE DEATH OCCURRED;
(d) Alter a certificate on file in the office of a local registrar.

STATEMENT OF PLACE OF DEATH

Special attention should be given to the satisfactory completion of EACH portion of this item. The city or town and street address or route number refer to PLACE WHERE THE DEATH OCCURRED. For deaths occurring in hospitals, maternity homes, or institutions, the name of the place and length of stay MUST be stated.

STATEMENT OF USUAL RESIDENCE OF DECEASED

Regardless of the fact that the person may have lived his entire life at the place of death, ALWAYS COMPLETE ALL PARTS OF THIS ITEM. In case a person has resided in the county where death occurred for less than one year, give address of FORMER RESIDENCE. The post office of the deceased may be in a county or state other than the county of actual residence.

IDAHO CODE ANNOTATED—CHAPTER 38, SECTION 206.

The personal and statistical particulars (items 1 to 16) shall be authenticated by the signature of the informant, who may be any competent person acquainted with the facts.

The statement of facts relating to the disposition of the body shall be signed by the undertaker or person acting as such.

The medical certificate shall be made and signed by the physician, if any, last in attendance on the deceased, who shall specify the time in attendance, the time he last saw the deceased alive and the hour of the day at which death occurred. And he shall further state the cause of death, so as to show the course of disease or sequence of causes resulting in death, giving the primary cause, and also the contributory causes, if any, and the duration of each. Indefinite and unsatisfactory terms, indicating only symptoms of disease or conditions resulting from disease, will not be held sufficient for issuing a burial or removal permit; and any certificate containing only such terms as defined by the state registrar as indefinite and unsatisfactory, shall be returned to the physician for correction and definition. The International classification of the causes of death shall be used by all physicians in stating the cause of death in the medical certificate. Causes of death, which may be the result of either disease or violence, shall be carefully defined; and if from violence, its nature shall be stated, and whether (probably) accidental, suicidal, or homicidal.

ADDITIONAL REMARKS by Physician.....

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JUL 21 1983

State of Idaho

CERTIFICATE OF DEATH

67- 5704
State File No.
Local Reg. No. 243
Reg. Dist. No. 120

TYPE OR PRINT IN PERMANENT INK

DECEDENT

1. DECEDENT – NAME (First / Middle / Last)	2. SEX	3. DATE OF DEATH (Mo., Day, Yr.)
Daniel Ray Kopp	Male	June 13, 1967

4. RACE – (White, Black, American Indian, Japanese, etc.)	5a. AGE – Last Birthday (Yrs.)	5b. UNDER 1 YEAR (Mos. / Days)	5c. UNDER 1 DAY (Hours / Mins.)	6. DATE OF BIRTH (Mo., Day, Yr.)	7a. COUNTY OF DEATH
White	20			July 25, 1946	Kootenai

7b. CITY, TOWN OR LOCATION OF DEATH	7c. HOSPITAL OR OTHER INSTITUTION – Name (If not in either, give street and number)	7d. IF HOSP. OR INST. Indicate DOA; OP/Emer. Rm., Inpatient (Specify)
Coeur d'Alene	Coeur d'Alene Lake	----------

8. STATE OF BIRTH (If not in U.S.A., name country)	9. CITIZEN OF WHAT COUNTRY	10. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	11. SURVIVING SPOUSE (If wife, give maiden name)	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? (Yes or No)
Idaho	USA	Divorced	----------	No

13. SOCIAL SECURITY NUMBER	14a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	14b. KIND OF BUSINESS OR INDUSTRY
501-52-3073	Miner	Silver Mining

PARENTS

15a. RESIDENCE – STATE	15b. COUNTY	15c. CITY, TOWN OR LOCATION	15d. STREET AND NUMBER	15e. INSIDE CITY LIMITS (Yes or No)
Idaho	Shoshone	Smelterville	General Delivery	Yes

16a. FATHER – NAME	16b. BIRTHPLACE	17a. MOTHER – MAIDEN NAME	17b. BIRTHPLACE
Ervin Kopp	North Dakota	Martha Thoreson	North Dakota

18a. INFORMANT – NAME	18b. MAILING ADDRESS (Street or R.F.D. No. / City or Town / State / ZIP)
Ernest Kopp	E. 17422 Mission Greenacres, Washington 99016

DISPOSITION

19a. BURIAL, CREMATION, REMOVAL (Specify)	19b. DATE	19c. CEMETERY OR CREMATORY – NAME	19d. LOCATION (City or Town / State)
Cremation	July 19, 1983	Yates Crematory	Coeur d'Alene, Idaho

20a. MORTICIAN (Signature)	LICENSE NO.	20b. NAME OF FACILITY	20c. ADDRESS OF FACILITY
Lee Fairfield	M623	Yates Funeral Home	Coeur d'Alene, Idaho

CERTIFIER

IF DEATH WAS DUE TO OTHER THAN NATURAL CAUSES, THE CORONER MUST COMPLETE AND SIGN THE CERTIFICATE

To be Completed by ATTENDING PHYSICIAN Only

21a. I hereby certify that I attended the deceased from _____ to _____; I last saw the deceased alive on _____. To the best of my knowledge, death occurred at the time, date and place and due to the cause(s) stated.

(Signature and Title) ▶

21b. DATE SIGNED (Mo., Day, Yr.)	21c. HOUR OF DEATH
	M

To be Completed by CORONER Only

22a. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated.

(Coroner's Signature) ▶ William T. Wood

22b. DATE SIGNED (Mo., Day, Yr.)	22c. HOUR OF DEATH
7-19-'83	Unknown M

22d. PRONOUNCED DEAD (Mo., Day, Yr.)	22e. PRONOUNCED DEAD (Hour)
ON 1983	AT Unknown M

NAME AND ADDRESS OF CERTIFIER (PHYSICIAN OR CORONER) (Type or Print)

23. William T. Wood, M.D. 212 S. 11th St., Coeur d' Alene, Idaho 83814

REGISTRAR	DATE RECEIVED BY REGISTRAR (Mo., Day, Yr.)
24a. (Signature) ▶ Patricia Strasser	24b. July 19, 1983

CAUSE OF DEATH

CONDITIONS IF ANY WHICH GAVE RISE TO IMMEDIATE CAUSE STATING THE UNDERLYING CAUSE LAST

25. IMMEDIATE CAUSE [Enter only one cause per line for (a), (b), and (c)]

PART I

(a) Cause Unknown. — Interval between onset and death: _____

DUE TO, OR AS A CONSEQUENCE OF:

(b) Probable accidental Drowning — Interval between onset and death: Sudden

DUE TO, OR AS A CONSEQUENCE OF:

(c) _____ — Interval between onset and death: _____

PART II — OTHER SIGNIFICANT CONDITIONS – Conditions contributing to death but not related to cause given in PART I (a)

26. AUTOPSY (Yes or No): No

27a. ACC., SUICIDE, HOM., UNDET., OR PENDING INVEST. (Specify)	27b. DATE OF INJURY (Mo., Day, Yr.)	27c. HOUR OF INJURY	27d. DESCRIBE HOW INJURY OCCURRED
Prob. accident	June 13, 1967	Unknown M	Automobile went into lake

27e. INJURY AT WORK (Yes or No)	27f. PLACE OF INJURY (At home, farm, street, factory, office building, etc. (Specify))	27g. LOCATION (Street or R.F.D. No. / City or Town / State)
No	Lake Cour d'alene off I-90	East of Cour d'alene, Idaho

JUL 25 1983

5704